COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Estimates

WEDNESDAY, 19 OCTOBER 2016

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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Wednesday, 19 October 2016

Members in attendance: Senators Bilyk, Carol Brown, Jacinta Collins, Dastyari, Di Natale, Duniam, Farrell, Griff, Kakoschke-Moore, Leyonhjelm, Lines, McCarthy, McGrath, Moore, Nash, O'Neill, Polley, Reynolds, Rice, Siewert, Smith, Urquhart, Waters, Watt, Williams, Xenophon.

HEALTH AND AGEING PORTFOLIO

In Attendance

Senator Nash, Deputy Leader of The Nationals, Minister for Local Government and Territories, Minister for Regional Communications Minister for Regional Development

Senator McGrath, Assistant Minister to the Prime Minister

Department of Health

Whole of Portfolio

Mr Martin Bowles PSM, Secretary

Professor Brendan Murphy, Chief Medical Officer

Dr Tony Hobbs, Deputy Chief Medical Officer

Ms Alison Larkins, Deputy Secretary, Chief Operating Officer Group

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

Mr Andrew Stuart, Deputy Secretary, Health Benefits Group

Dr Wendy Southern PSM, Deputy Secretary, National Programme Delivery Group

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

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

Dr Margot McCarthy, Deputy Secretary, Ageing and Aged Care

Mr Matt Yannopoulos, First Assistant Secretary, Portfolio Investment Division

Mr Craig Boyd, Chief Financial Officer, Portfolio Investment Division

Mr Charles Wann, Chief Budget officer, Portfolio Investment Division

Ms Judy Develin, Acting First Assistant Secretary, People, Capability and Communication Division

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

Ms Susan Parker, Assistant Secretary, Communications Branch, People, Capability and Communication Division

Ms Donna Moody, First Assistant Secretary, Health State Network

Mr Craig Rayner, Assistant Secretary, Capital and Assessment Branch, Health State Network

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

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

Mr Terry Green, Acting First Assistant Secretary, Information Technology Division

Mr Mark Booth, First Assistant Secretary, Health Systems Policy Division

Mr Matt Williams, Acting Assistant Secretary, International Strategies Branch, Health Systems Policy Division

Outcome 1

Ms Bettina Konti, First Assistant Secretary, Digital Health Division

Ms Alanna Foster, First Assistant Secretary, Research Data and Evaluation Division

Mr Mark Booth, First Assistant Secretary, Health Systems Policy Division

Mr Matt Williams, Acting Assistant Secretary, International Strategies Branch, Health Systems Policy Division

Ms Natasha Cole, First Assistant Secretary, Health Services Division

Dr Andrew Singer, Principal Medical Adviser

Adjunct Professor Debra Thoms, Chief Nursing and Mid-Wifery Officer

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

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

Ms Samantha Roberson, Executive Director, Evidence, Advice and Governance Branch, National Health and Medical Research Council

Outcome 2

Ms Lisa McGlynn, Acting First Assistant Secretary, Population Health and Sport Division

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

Ms Jackie Davis, Assistant Secretary, Tobacco Control Branch, Population Health and Sport Division

Ms Bobbi Campbell, First Assistant Secretary, Indigenous Health Division

Mr David Hallinan, First Assistant Secretary, Health Workforce Division

Mr Mark Booth, First Assistant Secretary, Health Systems Policy Division

Ms Alanna Foster, First Assistant Secretary, Research Data and Evaluation Division

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

Ms Natasha Cole, First Assistant Secretary, Health Services Division

Dr Andrew Singer, Principal Medical Adviser

Adjunct Professor Debra Thoms, Chief Nursing and Midwifery Officer

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

Mr Peter May, General Manager, Food Safety and Regulatory Affairs

Dr Trevor Webb, General Manager, Food Information, Science and Technology

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

Outcome 3

Ms Lisa McGlynn, Acting First Assistant Secretary, Population Health and Sport Division

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

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

Ms Judith Lind, National Manager, Operations, Australian Sports Anti-Doping Authority

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

Mr Matt Favier, Acting Chief Executive Officer, Australian Sports Commission

Mr Dean Kenneally, Acting Director, Australian Institute of Sport

Mr Michael Thomson, General Manager, Participation and Sustainable Sports, Australian Sports Commission

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

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

Outcome 4

Ms Maria Jolly, First Assistant Secretary, Medical Benefits Division

Mr Andrew Simpson, Acting Assistant Secretary, MBS Reviews Unit, Medical Benefits Division

Dr Megan Keaney, Medical Officer, MBS Reviews Unit, Medical Benefits Division

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

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

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

Mr Jaye Smith, Assistant Secretary, Primary Care and Diagnostics Branch, Medical Benefits Division

Ms Penny Shakespeare, First Assistant Secretary, Pharmaceutical Benefits Division

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

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

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

Mr Simon Cotterell, First Assistant Secretary, Health Provider Compliance Division

Mr Mark Booth, First Assistant Secretary, Health Systems Policy Division

Mr Matt Williams, Acting Assistant Secretary, International Strategies Branch, Health Systems Policy Division

Ms Alanna Foster, First Assistant Secretary, Research Data and Evaluation Division

Dr Andrew Singer, Principal Medical Adviser

Mr Charles Maskell-Knight, Principal Adviser, Health Systems Policy Division

Adjunct Professor Debra Thoms, Chief Nursing and Midwifery Officer

Outcome 5

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

Ms Lisa McGlynn, Acting First Assistant Secretary, Population Health and Sport Division

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

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

Associate Professor Tim Greenaway, Principal Medical Adviser

Dr Larry Kelly, First Assistant Secretary, Medicines Regulation Division

Ms Adriana Platona, First Assistant Secretary, Medical Devices and Product Quality Division

Mr David Weiss, First Assistant Secretary, Regulatory Practice and Support Division

Mr Bill Turner, Assistant Secretary, Office of Drug Control

Mr Mark Booth, First Assistant Secretary, Health Systems Policy Division

Ms Alanna Foster, First Assistant Secretary, Research Data and Evaluation Division

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

Dr Andrew Singer, Principal Medical Adviser

Adjunct Professor Debra Thoms, Chief Nursing and Midwifery Officer

Dr Masha Somi, Assistant Secretary, Immunisation Branch

Outcome 6

Ms Rachel Balmanno, First Assistant Secretary, Ageing and Aged Care Services Division

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

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

Ms Kerrie Westcott, Assistant Secretary, Residential and Flexible Care Branch, Ageing and Aged Care Services Division

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

Mr David Laffan, Assistant Secretary, Prudential and Approved Provider Regulation Branch, Aged Care Policy and Regulation Division

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

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

Ms Rae Lamb, Commissioner, Aged Care Complaints Commissioner

Ms Kim Cull, Commissioner, Aged Care Pricing Commissioner

Committee met at 09:00

CHAIR (Senator Duniam): I declare open this meeting of the Community Affairs Legislation Committee on 19 October 2016. The Senate has referred to the committee the particulars of proposed expenditure for 2016-17 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 2 December 2016 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 no later than 28 October 2016.

The committee's proceedings today will begin with its examination of the Health Portfolio commencing with whole of portfolio and corporate matters. The committee will then continue with the Department of Health and other portfolio agencies as listed on the program.

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 departments and agencies which are seeking funds in the estimates are relevant questions for the purposes 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 a discretion to withhold details or explanations from the parliament or its committees unless the parliament has expressly provided otherwise.

The Senate has resolved also that an officer of a department of the Commonwealth shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude questions asking for explanations of policies or factual questions about when and how policies were adopted. I particularly draw the attention of witnesses to an order of the Senate of 13 May 29 specifying the process by which a claim of public interest immunity should be raised. Witnesses are specifically reminded that a statement that information or a document should is confidential or consists of advice to government is not the 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.

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)

With regard to the agenda, while I have no capacity to rein in or draw to a close questions, I remind questions that the committee did agree to this rough agenda and it would be appreciated if, for the convenience of witnesses and other senators who have commitments in other committees, if we can try as best we can to stick to the timing we tentatively agreed to.

I welcome Senator Fiona Nash, Minister for Regional Development, Minister for Local Government and Territories and Minister for Regional Communications, representing the Minister for Health and Aged Care, and officers of the Department of Health. Minister, do you wish to make an opening statement?

Senator Nash: No, I do not, thank you, Chair. And welcome to your first estimates.

CHAIR: Thank you very much. We will then proceed to questions.

Senator POLLEY: I want to go to the whole-of-government portfolio and clarify for the benefit of the committee: is the Turnbull government still committed to keeping the Medicare freeze in place until 2020?

Mr Bowles: Yes, that is current government policy.

Senator POLLEY: Is the Turnbull government still committed to abolishing bulk-billing incentives for pathology?

Mr Bowles: That is still government policy.

Senator POLLEY: Is the Turnbull government still committed to cutting bulk-billing incentives for diagnostic imaging?

Mr Bowles: That is a policy that is still before the Senate and it is government policy at this stage.

Senator POLLEY: We are going well! Is the Turnbull government still committed to increasing co-payments for the PBS medicines by $5 for general patients and 80c for concessional patients?

Mr Bowles: That is a measure before the Senate and will still be policy until alternative savings have been found.

Senator POLLEY: Is the Turnbull government still committed to increasing the PBS safety net threshold so that patients spend more out of pocket before reaching the safety net?

Mr Bowles: I think you are talking about the MBS safety net one that is before the Senate. It is the same issue.

Senator POLLEY: Is the Turnbull government still committed to cutting the Medicare safety net?

Mr Bowles: It is the same issue. It is a measure before the Senate.

Senator POLLEY: Can you identify any of the health measures which the government took to the election which they have confirmed they are now not pursuing?

Mr Bowles: That is a broad question. I am not quite sure what you mean by that, sorry.

Senator POLLEY: They went to the election with a number of health measures. Are there any that I have not covered off there that the government have decided they are now not going to pursue?

Mr Bowles: The measures that government took to the election they are going to pursue. The measures you just ran through then were measures from budgets past. A number of them are before the Senate and will remain so until alternatives are found or those measures are passed.

Senator POLLEY: The day before the election the Prime Minister guaranteed that Australians would not pay more to see a doctor as a result of the freeze. Can you give the same guarantee?

Mr Bowles: Ministers and prime ministers make statements. I cannot comment on their views. Our job is to implement government policy.

Senator POLLEY: Has the department had conversations with officials from Treasury or Finance about the possibility of the Medicare freeze being lifted?

Mr Bowles: I have had none personally. Do we have discussions with Finance and Treasury on all issues all the time? Yes, we do. But there is nothing I am aware of at this point where we would have a conversation with Finance or Treasury about changing those issues. We have conversations with them on all measures all the time.

Senator POLLEY: I would imagine you do, but I just wondered if there had been any discussion about lifting it. Have you contributed modelling and information to inform Treasury costings in relation to the Medicare freeze being lifted? You have done none of that?

Mr Bowles: I would have to you take that on notice. Over time we would have provided information to Treasury, but there is nothing specific at the moment that I am aware of on that.

Senator POLLEY: On 23 May the health minister told ABC radio that Treasury and Finance were the reason she was unable to lift the freeze. What do you think she meant by that?

Mr Bowles: You would have to ask the minister. I have no idea what was meant. That was a statement by the minister and should be referred to the minister.

Senator POLLEY: You could take from that that work was underway at Health and that Treasury and Finance had blocked her from being able to lift the freeze. That could be interpreted from that, could it not?

Mr Bowles: I am not going to interpret what the minister has said.

Senator POLLEY: Quite clearly, you have not done any work with Treasury or Finance in relation to lifting the freeze.

Mr Bowles: That is not quite the way I have said it, but the measures before the Senate are still measures before the Senate. We will always look at options, as a department, but we are not in active consultation with Finance or Treasury at this particular point in time around removing those. That does not mean we do not always look at options around what we are doing as a department.

Senator POLLEY: Over the forward estimates, what was the difference between the hospital funding policies that the government and the opposition took to the last election?

Mr Bowles: What?

Senator POLLEY: Obviously, you would have been giving advice to the government. You would have then made an assessment of the difference between the policy announcements from the opposition and from the government.

Mr Bowles: Are you talking about this in relation to public hospital funding?

Senator POLLEY: Yes.

Mr Bowles: The Prime Minister, through the COAG process, came to an arrangement with first ministers in I think it was April this year on a deal with the states around a national cap of 6½ per cent going forward.

Senator POLLEY: Yes, but that was not the question. The question was: the policies that the government took to the election—

Mr Bowles: Which is that one.

Senator POLLEY: You would have costed those, as opposed to the commitments that were given by the opposition.

Mr Bowles: I cannot recall off of the top of my head. The only thing I can recall there is that I think the opposition's policy was similar to the government's but had more money—and I cannot remember the exact figure; I think it might have been $2 billion, from memory.

Senator POLLEY: Two billion dollars over four years. Yes, that is correct. The government took a number of health cuts to the election, as I said, including the freeze on Medicare rebates until 2020. I just want to make sure I have this clear: the department has not given any advice to the health minister about lifting that freeze.

Mr Bowles: I talk to the health minister all the time about options around the freeze and around all sorts of savings cuts that might or might not be on the table.

Senator POLLEY: If we are then looking at Medicare and at the digital payment services task force and the process outsourced to the MBS and the PBS claims and payments, is it correct that that work has been occurring since 2014?

Mr Bowles: Work initially started, I believe, in early 2014 about looking at a replacement for the payment system for Medicare and aged-care payments, yes.

Senator POLLEY: Was this a direct result of the 2014-15 budget measure?

Mr Bowles: The notion of looking at the payments system more broadly did get raised in the context of the budget, but it is in direct relationship with the fact that the system is quite old and is in need of fixing quite urgently.

Senator POLLEY: In preparation for the budget, did the department prepare a cabinet submission for each of the measures in the 2014-15 budget?

Mr Bowles: Again, I would have to take on notice specifically how all that went. It was before my time, so I cannot recall specifically. I can take that on notice, but the normal process would be yes.

Senator POLLEY: The decision to progress on outsourcing the MBS and the PBS claims and payments must have come from cabinet. Is that correct? Is that your understanding?

Mr Bowles: Not necessarily. Again, I would have to take it on notice because it is before my time, but it was a decision of the 2014-15 budget to look at an assessment of the claims and payments system for Medicare and to come up with a solution. That was way back in 2014, as we said, and a range of other things have happened since that time.

Senator POLLEY: Is it correct that the decision to approach the private sector in relation to the MBS and the PBS claims and payment information was a decision of the government?

Mr Bowles: They were all decisions of government. It is not unusual in government to approach the broader sector around a whole range of issues. We do it every day. Every department does it every day for the provision of government services.

Senator POLLEY: How many responses were there in response to the expression of interest back in 2014? Would you have that information?

Mr Bowles: I could take that on notice. There were more than eight, but I think for the ones that met the criteria—there was a round eight, from memory. But there were a lot more

than that who originally put in an EOI from my recollection. I can take that on notice as to the specific number.

Senator POLLEY: That would be appreciated. Did Telstra respond to the expression of interest?

Mr Bowles: Not to my recollection. Again, I can take that on notice.

Senator POLLEY: Did a commercial bank respond to the EOI?

Mr Bowles: I believe they did. Again, I am sure that there were some banking institutions that were involved at the time.

Senator POLLEY: Was the department preparing a proof of concept trial for implementation in 2017, and what was involved in that?

Mr Bowles: Sorry, 2017?

Senator POLLEY: Yes.

Mr Bowles: That is next year.

Senator POLLEY: Yes.

Mr Bowles: Sorry, can you ask the question again?

Senator POLLEY: Was the department preparing a proof of concept trial for implementation for next year and what was the process for that?

Mr Bowles: I think we have jumped a few steps. Just excuse me as I try to get this right. We have been talking about the 2014-15 budget measure that went to an expression of interest for a range of issues.

Senator POLLEY: That is right.

Mr Bowles: Since then, we have had this conversation in the last number of Senate estimates around what the department has been doing in looking at trying to come up with a solution for the payment system more broadly. We have been doing that. Since the election, as you would be aware, the Prime Minister made a commitment around how the payment system would be managed by government within government. That is a decision that has come from that. We are in the process of actually dealing with that at the moment.

Senator POLLEY: How far along have you got? Are you ready? Are you going to meet the deadline of next year?

Mr Bowles: That would be the plan at this stage.

Senator POLLEY: For when in 2017?

Mr Bowles: The first phase of this will be around co-design type concept. That is notion. Just excuse me while I just check one thing—yes, the intent would be, again, that we would look to do this in a co-design fashion with the stakeholders.

Senator POLLEY: This morning, the minister announced that work will commence on a replacement for the current digital payment IT system. The timing of it is interesting. Whose idea was it to announce this on the same day as estimates? Was it to limit scrutiny of the announcement before estimates? What was behind it?

Mr Bowles: I am not in control of when things get announced.

Senator POLLEY: So, the preparation was obviously done ready for today. How long was that in planning?

Mr Bowles: There has been a number of conversations with government since the election. We have provided advice to the minister on how we should proceed with this program—that is the co-design concept that I talked about—and then it is up to government when things get announced. Yes, they announced it this morning.

Senator POLLEY: The minister's press release states: 'A new system, which will support the government delivering aged care and Medicare payments.' What does this mean? Will there be a separate system which is then outsourced as well?

Mr Bowles: The first phase will be that we will go to a co-design concept. We will talk with the stakeholders, like the AMA, the consumers' forums, RACGP and a range of different groups. We will look at how best to implement a payment system and then look to be in the marketplace in that early next year time frame. It will be, as the Prime Minister announced through the election, operated by government and—like many of our systems—we will obviously have to use a third-party provider for the IT technical bits of the system, as is the case with just about every other system that we operate in government. We will work it that way.

Senator POLLEY: The process has commenced as of today. Is this another tender or is it an open tender process going forward?

Mr Bowles: At the moment, we will do the co-design work with the stakeholders. Ultimately, we will look to the market for what are payment gateway technologies that are out there that government can operate to address the problems that we do have with the quite old system that we have at the moment. I cannot really go into the detail, because it is part of the Department of Human Services portfolio in relation to how it operates. It is well known and well canvassed in these committees over time about the fact that it is a 30-odd year old system and it has got multiple complexities to it at the moment, which actually limit our ability around the payments issue.

Senator POLLEY: Can you rule out the involvement of a for-profit company in the process?

Mr Bowles: I am not in the business of ruling in and ruling out. We will look for a solution. I think the important issue here is that it is going to be operated by government and that is how we have configured the conversation with the stakeholders and that is how we intend to move forward.

Senator SMITH: It will be made and controlled by government. Is that what you are saying?

Mr Bowles: It will controlled by government. It will be operated by government, as the current systems are now. But there are IT companies or different groups that actually do work in the background. It happens right across government.

Senator POLLEY: What you are saying very clearly then is that this is not another case of outsourcing?

Mr Bowles: This is not an outsourced issue. If I go back to at least the last three Senate estimates, I have gone over this in quite some detail. We have always been looking at options.

We got to the election and there were a lot of clarifying remarks about how this would happen. That is how we are operating. We implement government policy.

Senator POLLEY: I think Senator Watt has a follow-up question.

CHAIR: Following on, Senator Watts?

Senator WATT: Yes.

CHAIR: Okay. Senator Watt will follow on and then we will have Senator Smith with a follow-up question.

Senator WATT: Can I just explore this issue a little bit further. Mr Bowles, you will appreciate that this press release has just been dropped on us this morning, so we just trying to get to the bottom of what is in mind. Senator Polley asked why it is that this announcement has mysteriously been dropped at exactly the time this estimates began. You do not know anything about that decision or when the decision was made to make an announcement?

Mr Bowles: I know it was put out this morning. I am not in control of when media releases go out from ministers' offices.

Senator WATT: When did the department provide final advice to the minister or ministers that this is the way to go?

Mr Bowles: That this is the way to go?

Senator WATT: That the government should pursue this process. When was the final advice provided?

Mr Bowles: It was not in relation to a media release. Again, that is a separate issue. In relation to this project, it has been a conversation since the election about what is the best way forward. We have been refining that since that time. I would have to probably it take on notice for specifically, but it has only been in the last few weeks that we have been able to finalise the program about how we want to proceed around the co-design model and then looking at what is an appropriate commercial solution around payments gateway—which is the technology piece that sits in the middle—and go from there. As to the minister's media releases, that is an issue for the minister.

Senator WATT: I perfectly accept that, but you are saying that the department's final advice—the submission, a briefing note or whatever it was—recommending this approach was provided to the minister some weeks ago?

Mr Bowles: It would be in the last few weeks. We have provided advice over time since the election, but there have been constant conversations about trying to work out how to look at the co-design concepts. That has been happening over the last few weeks. I could not tell you exactly when the last piece of advice was. I could take that on notice.

Senator WATT: You said that there have been a lot of discussions with ministers and their offices about this approach since the election. Has there been any direction given by ministers as to ring fencing certain parts of this approach from private sector involvement?

Mr Bowles: The approach has been has described by the Prime Minister during the election. It will be a system that would be operated by government. That is the concept under which we have been operating since that point in time. Our job is to implement the policy of the government of the day. That policy was quite specific at that point in time and that is the policy we are pursuing.

Senator WATT: Can I have little bit longer, if that is okay?

CHAIR: Knowing that Senator Polley has the call. I do not want to spend too long on follow-ups.

Senator POLLEY: This is part of us, because we need to understand what this co-design is.

Senator WATT: Had we known about this a little earlier we probably could have explored other ways to get these answers. It is a little strange, if that advice was provided a few weeks ago, that today of all days the government has dropped this. I appreciate that has nothing to do with you, Mr Bowles. Can you tell a bit more about this co-design concept? What exactly does that mean?

Mr Bowles: It is happening quite a bit with many government programs today. It has been particularly pursued in the aged care space. It is about working with the different stakeholders about what the best option is for how we would operate payments and claims system over time. So we would be looking at dealing with medical practitioners, the AMA, through the broad organisations, through aged-care providers. There would be lots of veterans groups, because they get payments as well. So we would be looking to work with a whole range of those to really understand their needs. This has always been the concept. This is not necessarily something we have just invented for this. Most of our projects these days are done in this co-design process. By co-design we basically mean government working with the stakeholders to try and work out how we can best deliver these programs.

This goes back to the current Medicare payments system, which is operated by Human Services. There are a number of issues with that particular system. It has been around for 30-odd years now. It is at the end of its useful life and probably has only a couple of years left—maybe three or four years left in the system. We want to make sure that we can work with the people that this impacts on to get it right. That is really how we are talking about co-design.

Senator WATT: Would you anticipate consulting with any private sector organisations as part of that co-design process?

Mr Bowles: Not in the context of co-design. There are already a number of already payment systems in the marketplace. They are commercial. There are a number of private sector operators who do this in the health space. We would not be anticipating bringing them into a co-design concept at this stage. If we are looking at the market for that commercial payments piece—the technology that sits in the middle—there are whole range of things that happen in health space already.

Senator WATT: You said before that your intention is to put this into the market place early next year, by which I presume you mean go to tender?

Mr Bowles: Yes. You would look for a request for proposals around a solution that meets the needs that come up through our co-design process around a government-operated payments and claims system for Medicare and aged care.

Senator WATT: What would be the sort of organisations that you would expect to respond to that sort of tender?

Mr Bowles: I do not think I could really predict any more in this space. There are a number of healthcare systems around the world nowadays that are looking at modernising

technologies. Our current system is quite antiquated in the technology sense. If you think about banks—and I am not suggesting they are the only solution, because they are definitely not—we pay wave, we do a whole lot of things. We do not have those mechanisms. There is far too much manual intervention that happens in the current system. We want something that technology can help, but we also recognise that there are a lot of people and providers out there, and we really want to understand how they operate and how we can help in that process. This will help in the broader conversation around compliance activities, around how we operate and how we run the MBS, the PBS and our aged care systems. There are whole range of things. So I would not want limit it to what might be out there. But we are not looking at a bank—it might have been Senator Polley who mentioned that before—or someone like that to come in and operate that. That is not what we are looking at. We are looking at a commercial solution around the technology bet that is the payments gateway. We will operate the system as it has been operated by government in the past.

Senator WATT: In answering that you mentioned—and I am paraphrasing here—that there are all sorts of commercial operators that you would like to have a look at what they do and what you can learn from that. So it would be intended to consult the private sector operators in designing this approach?

Mr Bowles: Not necessarily in the design of the approach. We have already been to the market in 2014, as we talked about before a bit, and there are a range of concepts out there. This was never an issue around privatising. This was an issue of dealing with the payments gateway, to use that sort of language, for government to pay providers in the MBS, PBS and ultimately the aged care sector. That is what we have been looking at the whole time. There are multiple ways to deliver that. One of them could be a total outsourced solution. We are not going down the path of an outsourced solution. However, we do need the technology to do payments gateways—to move payments between government and providers and how we deal with claims and payments in the system.

Obviously we need to understand the technologies out there. We are not necessarily going to pick up anything from any commercial operation about how they would operate things. Government is going to operate this. We do need a new solution. We will look to what is the best solution for government to continue to make payments. We make something like 600,000 payments, worth about $50 billion, a year, through our payment gateways. It is not insignificant. We want to make sure that we get the right technology and solution for that system.

Senator WATT: Would you envisage that the tender could be responded to by consortia that might have a combination of government and private entities putting together a combined bid? Is that something that you would consider?

Mr Bowles: I do not think we would see anything coming from government-commercial consortia in that sort of form. Again, we are looking at a technology solution that government can operate within the context of the policy parameters that we have. It would be unusual, I think, for a private sector group to work with us as a government to come up with a solution. Ultimately, we would work with whoever is the technology partner to deliver, as we do in many other parts of government business today.

Senator WATT: If this system will be owned operated and whatever else by the public sector, I am struggling to understand why there is a need to go to tender?

Mr Bowles: Because there are many commercial providers of the technical piece that sits in the middle. I do not think it would be wise for us to pick a particular piece of technology from a commercial provider out there and exclude others. We need to look at what is the best. So we will need to go to the market to look at what is the best.

Senator WATT: So a company like Telstra Health or a bank might be okay to operate that or provide that part of this system?

Mr Bowles: I am not going to limit what might be out there. If you look at some of the private insurers, they run their own payments issues. If you look at healthcare systems around the world, there are some interesting technologies that some of the Europeans use. There are different technologies out there all over the place. I do not want to really nail anything down. I am not aware of Telstra's capability in this field. We are looking at what the best technology solution is for us to make payments, and we are going to do that through this co-design process.

Senator WATT: So you are open to organisations such as a Telstra Health or a private health insurer or an international provider, whoever they are—

Mr Bowles: I am not going to say that I am open to a Telstra Health or anything. I am open to the technology solution that best fits the needs of a government-operated payments and claims system for Medicare and aged care.

Senator WATT: Beyond the technical support, is there any other aspect of this new approach that you would envisage the private sector might be able to operate better than government?

Mr Bowles: There is the technical piece in the middle. It is not all services. There are commercial products that you would use as the gateway, if you like. Modern payments gateways are pieces of software that move money and do things. Banks do it all the time; the Reserve Bank does it all the time; private insurers to it all the time; other operators do it all the time. It is how money moves. That is the technical piece that sits in the middle. We have to look at that. If we were to develop that—we do not have expertise in it. We want the technical solutions.

Senator WATT: I can imagine that in designing a system like this there are so many bits and pieces—someone does the technical bits, someone does this bit, someone does that bit. Is there any other part of the package that you could see a private sector organisation partnering with government to offer?

Mr Bowles: Not particularly at this stage. This will be a project that will be run by us in Health with the support of Human Services in particular, because they are the current operator of the system. It is run by us because we have the policy responsibility for health. That is quite a deliberate choice at the moment, that we are the policy provider for health.

Senator WATT: I do not really know how the Medicare claims system works. I just give my card and get my money back, like most people. What patient information is transferred in that process?

Mr Bowles: This is a technical issue around the payment for a service, not patient records per se. So we are not transferring private payment information; we are transferring a payment from government to provider.

Senator WATT: But if I go into a GP because I have a bad headache, and I have my consultation, go back out, pay my money, use my Medicare card—doesn't something need to be transmitted in order to determine the level of rebate I get?

Mr Bowles: That is determined by the provider, and then the payment is made. You have to separate two things. Payments is about money transfers for service provided, largely. Patient records are held by doctors. We have the My Health Record issue, which is a completely different set of circumstances. That is about understanding and coming up with a digital solution in that context for patient-related data. These two things are completely separate and completely different sets of issues.

Senator WATT: Can I ask a couple of quick questions about things that Senator Polley also touched on earlier. Senator Polley ran through a series of policy commitments from the government prior to the election in the health space that involved cuts or freezes and things like that. I think your answer to every one of those was that they are still government policy. Are there any of those that you have been requested to not progress further—to just drop altogether?

Mr Bowles: Not in that context, that I am aware of. We are working on all of them to find solutions, because they are obviously in the Senate and we would like to see a range of these issues resolved, because clearly they do have impacts. There are good policy reasons for a range of these things and again we need to be able to keep working on them, but we are not trying to stop anything at this particular time.

Senator WATT: Is it the department's view that it would like to see those initiatives continue and get through the Senate?

Mr Bowles: I would like to see a range of initiatives that are in the Senate go through, yes.

Senator WATT: Things like keeping the rebate freeze and abolishing bulk-billing incentives for pathology and diagnostic imaging?

Mr Bowles: These are matters for government. We obviously advise the minister, the minister puts things to the government, and the government makes decisions. It is ultimately up to the government and the parliament to pass these sorts of issues.

Senator WATT: But it is the department's view that they would recommend that they still proceed?

Mr Bowles: It is the department's view that these are quite sensible policy issues. It is up to government to decide on the way that those things go through in a parliamentary sense.

Senator WATT: In your earlier responses to Senator Polley—and again I am going to be paraphrasing here—you mentioned that you talk to the minister all the time about policy options, including freezes, cuts and things like that. Are there any other freezes or cuts that you have spoken about with the minister since the election?

Mr Bowles: No.

Senator WATT: So the only ones that are on the table and under consideration are the ones that were in place before the election?

Mr Bowles: The only ones that we have been discussing are the ones that are there in that context. I just need to be clear that the pauses issue is not something that is in front of the

Senate; they are things that are in place. They are policy positions of the government at this stage.

Senator WATT: The pauses issue, sorry?

Mr Bowles: Yes, the pauses. They are happening, as we know.

Senator WATT: Yes. Where does a decision to outsource an aspect of the health service begin? Does it begin with a scoping study? What is the sort of generic process that leads up to those sorts of decisions?

Mr Bowles: I do not think we ever set out really in that context to outsource. We set out to look for a solution—the best solution—and we will go from there. We do not start with an outcome in mind to arrange these things from that perspective.

Senator WATT: Yes, I appreciate that. I am just trying to think of what the terminology is. If you are looking at a current service that you provide or an approach that you take and there is a view that it could be done better, what is the usual first step?

Mr Bowles: If I can just talk about what the department would do. We would get a group of people together and we would start to have a conversation about what are the best options. Unfortunately, if we go to the payments system quite specifically, that got characterised in something that was not. I had a group of people who were talking about what is the best option for payments going forward given the problem with the payments system that had been identified. We were looking at options and that is where we were.

Senator WATT: So in this instance for the digital payments task force someone had an idea that it could be improved and you pulled a group of people together to start thinking about it and advice was given.

Mr Bowles: Yes.

Senator WATT: What would you see as the next biggest priorities where you would need to get a group of people together to start thinking about how services could be improved?

Mr Bowles: It is hard to say. We do these things all the—

Senator WATT: As good as the system is, I am sure there are things that can be improved.

Mr Bowles: There always are. We do this stuff all the time. If we go back to some of the issues with drugs, the Ice Taskforce was developed to look at the best way to deliver services in that space. Internally in the department I might have an internal operational issue that I have a problem with. If I want to work out the best way to do that, I will pull a small group together—it usually will not be called a task force—and we will sort of brainstorm the best way we actually do things. It happens all the time.

Senator WATT: Are there a couple of examples that you give where that sort of thing is happening at the moment in the health system—things that the average person in the street would relate to?

Mr Bowles: No, we do not have too many of those sorts of issues going at the moment. The last really big one was the Ice Taskforce, which was run out of PM&C—with us, obviously. I did have the task force looking at the best way that the payment system would operate. I have changed that structure now. It is part of my departmental structure because it is

going to be operated by government, and that is the way it has been characterised. That is how we do things. We will move with government-of-the-day policy, effectively.

Senator WATT: This is my last question. Just back to the issue about data and your approach: I understand that HICAPS data is captured by insurers through the payment process if you have private health insurance. Would it be different under this system?

Mr Bowles: HICAPS is the payments mechanism for private health insurance. It does not move the patient data from one place to another. If you go to your physio, for instance, you can swipe your insurance card, whatever it happens to be, and then pay whatever extra it is for your physio. I do that whenever I go to the physio. I swipe my card and then I swipe my other card. It is about payment. The insurer is paying the provider and I am paying the provider, so it is a two-way thing happening.

Senator SMITH: Turning to the indexation of Medicare, when was the pause on Medicare indexation introduced?

Mr Bowles: It was quite a while ago, but I will get Mr Stuart to give you the exact date.

Mr Stuart: It is a slightly complex answer relating to different parts of Medicare. Did you have a particular part of Medicare in mind?

Senator SMITH: No. I am happy to hear a complex answer at Senate estimates, so go for it.

Mr Stuart: We put this on the record as well in the last hearings. In terms of when various things—

Senator SMITH: If you have the document there, Mr Stuart, you might like to distribute it.

Mr Stuart: Just bear with us for a second while we find our place. In the 2013-14 budget the then government announced that the indexation of MBS schedule fees would shift from November to July, and—

Senator SMITH: That was the Labor government?

Mr Stuart: Yes, it was at the time.

Senator SMITH: And the minister was?

Mr Stuart: I do not have that here in front of me, the minister of the day in the 2013-14 budget. Indexation was then frozen for eight months. In the 2014-15 budget the government announced a measure to pause the indexation of some Medicare benefit schedule fees et cetera. That was on 13 May 2014, and that included indexation for all non-GP services, specialist and allied health services in particular. It was then scheduled to recommence from 1 July.

Senator SMITH: So the freeze began in the 2013-14 budget?

Mr Stuart: Yes.

Senator SMITH: What was the estimated saving in the 2013-14 budget?

Mr Stuart: At that time there was an estimated saving of $665 million over four years.

Senator SMITH: Thanks very much. Can you also take on notice to verify the statement from Tanya Plibersek, who was the health minister at the time, that doctors earn enough

money to bear the federal government's controversial freeze on MBS rebates. That was reported in *Australian Doctor* on 22 May 2013.

Mr Stuart: I am sorry; I missed the part at the end of the question.

Senator SMITH: I was asking you to verify the accuracy of this statement by Tanya Plibersek—'Doctors earn enough money to bear the federal government's controversial freeze on MBS rebates'—which she made on 22 May 2013. It is in *Australian Doctor*. You can make sure that I have quoted it accurately, Mr Stuart?

Mr Bowles: We will take that on notice.

Senator SMITH: Going to the issue of the Medicare payments system, this is the same system that Dr Gannon of the AMA called rusty and antiquated.

Mr Bowles: I believe that was his phrase.

Senator SMITH: I am more interested in what the risks are if no other action is taken around the Medicare payments system. You said, Secretary—correct me if I am wrong—that 600 million payments are made over the system every year.

Mr Bowles: That is correct, yes—around $50 billion.

Senator SMITH: Six-hundred million payment transactions representing $50 billion?

Mr Bowles: That is correct.

Senator SMITH: Can you give us an example of the sorts of payments that are made over the Medicare payments system? You mentioned going to a physio, for example.

Mr Bowles: It will not be in the physio—largely doctor payments. If you go to a doctor and you are bulk-billed, basically the transaction happens there between the doctor and Medicare, or Human Services, as it is at the moment. There are payments to the PBS. They do PBS payments. They also do some of the incentive payments across the provider system. There are a range of payments in that, and in the aged-care space this particular system is different.

Senator SMITH: If the system failed, how would you describe that—catastrophic, a slight mistake?

Mr Bowles: If the system failed, we would not be making payments to providers for the services they deliver.

Senator SMITH: So that would be quite a serious issue?

Mr Bowles: It would be serious.

Senator SMITH: In your opening responses to, I think, Senator Polley, you talked about the urgency required in fixing the system. Correct me if I am wrong: the urgency is because, if no action is taken, the consequences are serious, not just for the Department of Health but also for those people that are using the system to access payments or to receive payments?

Mr Bowles: Yes, that is correct. It is serious for us. Currently the payments are made by Human Services, so they would be better placed to talk about some of the issues that they will face. But, clearly, if providers are not being paid for their services, they will have their own issues around how they pay their staff and do all the things that they need to do.

Senator SMITH: How long has the conversation been happening in government about the suitability of the existing Medicare payments system?

Mr Bowles: I could not give an accurate answer to that, but my recollection is that this has been happening for many, many years about different options, and there have been different attempts to future-proof it, which have not really been successful over time. Effectively, this system is about 200 applications and 90 databases, and it has evolved in so many different ways, with different positions of different governments, over about 30 years.

Senator SMITH: 'Evolved' makes it sounds like it is elegant. Has it evolved clumsily?

Mr Bowles: I think someone described it as: we are still trying to drive a 1984 Commodore in a current car race, for instance, against whatever the modern technologies are that are out there. There are all sorts of different analogies, I suppose, that you could use.

Senator SMITH: A 1984 Commodore is probably leaded, so you are probably not allowed to drive it at all! Just to home in on the point: a lack of action has consequences for those people who are receiving payments over the system?

Mr Bowles: Yes, that is true. My personal view would be that doing nothing is not an option.

Senator SMITH: You also said that over many, many years, this issue has been discussed and explored; people have been looking for solutions. So this is not the first time that government has sought to find an answer to what Dr Gannon called a rusty and antiquated system.

Mr Bowles: Human Services would be best placed to give you the history of how many, because I just do not have that. But I do know that this is been an issue for quite a while. As I said, it is 200 applications, 90 databases, 30 years of whatever has been going on in the health space, and we are a little bit different to what we were in the eighties. It is a complex set of issues and it really just needs to be dealt with.

Senator SMITH: It was built in an era of cheques and walking into a bank and depositing a cheque and having a passport. It was not built for an era where you 'tap and go', I think that is the terminology.

Mr Bowles: No, it was not. Everything has been modified time and time again, which is part of the complexity. That is my evolved comment—it is evolved because policy has changed many times over 30 years and technology has changed many times over 30 years, except in this particular case. So we cannot do the modern stuff. We talk about a number of things that have happened. In the current system, yes, a lot is done electronically, but a small amount—or a small amount in percentage term—sometimes is described as 'manual intervention'. When you do 600 million transactions a year, one per cent is a lot, and it is a lot bigger than one per cent. There are all these sorts of issues that come into this. Absolute numbers in this space are what really does the damage.

Senator SMITH: To put the process into layman's terms, and again correct me if I am wrong, it is like the Department of Health walking into Harvey Norman, looking across the shelves, finding a system or finding a platform, deciding it wants to buy it, taking it home to the Department of Health and having it installed—

Mr Bowles: In very simple terms, yes.

Senator SMITH: if I had to explain it to my parents.

Mr Bowles: That would be close to it.

Senator Nash: I think it is important to note too that the Prime Minister has been very clear that the system is going to be owned and operated by the government, and we will not be outsourcing any part of the system.

Senator POLLEY: When were the GP rebates last indexed? By which government and in which year?

Mr Bowles: I will get my colleague back to the table for that one. I think he said it happened in early 2013—that is when the first freeze came on—or something like that.

Mr Stuart: I was just looking in the *Hansard* from the May hearings—I read the answer to that question this morning.

Senator Nash: It will be there somewhere.

Mr Stuart: Oh, yes. Fees for GP attendances were last indexed on 1 July 2014 and so the first indexation date that was missed would have been 1 July 2015.

Senator DI NATALE: I have whole lot of questions about the freeze but I will leave them till later. There have been some pretty major changes to the Department of Health's outcomes. I would like to explore that a little bit. Can you talk me through the rationale for the changes in brief?

Mr Bowles: I am trying to remember—it is probably not in this document, but in our portfolio budget statement around budget time, because that is when we put the changes into action, if you like. We had an outcome structure that was quite old and very difficult to understand. I used to come here and everyone would ask me where they could ask their questions and I could never have really answer because there were so many crossovers and overlaps and all sorts of weird and wonderful combinations.

Senator DI NATALE: That would not be a criticism of your predecessor, would it?

Mr Bowles: That would definitely not be a criticism of my predecessor. It is more about an evolution about how we do that. I would never criticise my predecessor.

Senator DI NATALE: Neither would I!

Mr Bowles: What we tried to do is simplify it and get it into an outcome and program structure so it is a bit easier for everyone to understand what we are doing. That does not mean I will not get confused about which outcome is what, because, at the end of the day, if you look at the number of programs that we have and subprograms, this is probably one of the most complex portfolios in government. We are now down to outcome 1, health system policy. That is really trying to look at how we design and do things in the system. Outcome 2 is health access and support. Where we are looking at access and support issues like PHNs, primary health networks, they are in there, and how we deal with certain things some mental health and the like. They fit in there. Outcome 3 is sport and recreation, which the broader sport issue. Outcome 4 is individual health benefits. There we have the MBS, the PBS and all of the issues that go in that space. Outcome 5 is regulation, safety and protection, because we have a large regulatory function as well. And Outcome 6 is ageing and aged care. We are just trying to get it into a more structured approach that is easier for everyone to understand, including ourselves. Underneath that we set up the program structure. There is a lot more flexibility in the way we can deliver the programs we are asked to.

Senator DI NATALE: I understand that and that makes sense. Why has population health been abolished as a stand-alone area?

Mr Bowles: Because it fits with the broader—now you have me trying to work out where it actually sits in the overall thing. It will be with the broader issue. It will be in outcome 2. Population health is part of the broader issues that we deal with.

Senator DI NATALE: Do you want to tell me exactly where it sits?

Mr Bowles: It is in outcome 2.

Senator DI NATALE: But where?

Mr Bowles: I do not have the—

Senator DI NATALE: Is it within preventative health and chronic disease support?

Mr Bowles: Yes.

Senator DI NATALE: This is a government that is responsible for the abolition of Preventative Health Agency. We lose population health as a stand-alone item. The focus on population health seems to be diminishing consistently. We know it is a cost-effective investment. It is hard to escape the conclusion that it represents a watering down of population health as a priority for government.

Mr Bowles: From my perspective, that is not true. Population health is a particular term, but the whole notion of this structure is to try and deal with the entirety of health: preventative health, chronic disease, primary health care. They all fit into a broad—population health, if you like. It does not mean we are devaluing the value, if you like, of population health issues. They are all in there.

Senator DI NATALE: That rings alarm bells for us and perhaps we will explore that a bit later with some of the more specific measures. Related to that is the issue of flexible funds. A lot of those were delivering population health programs. Based on a previous answer to a question on notice, there was a statement made that said that flexible funds effectively now cease to exist and that they will be rolled into this new program structure. Again, can you explain your thinking as to why? Flexible funds, for people who are not aware, are a range of programs, many of them with a population health focus: Indigenous health; HIV. A range of Indigenous health and a range of specific programs with a strong population health focus—gone. I will get to the issue of funding in a moment. What was the rationale?

Mr Bowles: They are not gone.

Senator DI NATALE: Gone in the current form.

Mr Bowles: They are gone in the language of 'flexible funds'. To be really frank, they are not flexible.

Senator DI NATALE: They have been flexible. This government has treated them as very flexible.

Mr Bowles: They are program funds that we use for a range of different things that you mentioned. They are still all there. But we want to get away from the notion that everything is just flexible. We have specific purposes for these programs. They have been folded into—and I just cannot give you the direct line where they are—our broader outcome and program structure.

Senator DI NATALE: This is, I think, really important.

Mr Bowles: The money has not gone.

Senator DI NATALE: That is where we will get to next. I can understand your thinking, because it was a big pool of unrelated programs lumped together. You have moved them across into—

Mr Bowles: Into a proper program structure.

Senator DI NATALE: the relevant outcomes to support the work within each of those outcomes?

Mr Bowles: That is right.

Senator DI NATALE: The funding has been cut, and I am not talking specifically about this year, because I do not know. I cannot work it out based on this new program structure, but in previous years we have seen a reduction in funding to those programs—

Mr Bowles: That is correct, and we have gone through all those.

Senator DI NATALE: The challenge for us now is to work out what the previous structure looked like, with the funding, compared to what you have done now. I suspect you will not be able to provide us with this information today. Perhaps that is not the case. I suspect you anticipated this question. I am not sure you have this information at hand. What I would like to see is: what were the flexible funds worth? And I would like a line item of each of those funds. Then I would like an outline of where each of those funds now sit and how much they are being funded—what is the funding envelope for each of those—and how does that compare to the previous structure? You can see where I am coming from. It is very hard for us to make a direct comparison.

Mr Bowles: Absolutely. I totally get it. We have provided, in the past, information around the flexible funds. That was not everything, but it was a group of funds that ended up being called flexible funds for some unknown reason. We have, in the past, given you a breakdown of what the spend was, what the budget changes were over time, and got to a point in time. I think it will be difficult because we tried to get them into relevant programs. You mentioned earlier that it was a mixed bag of things that did not necessarily relate that well. Some of them will have been broken down; some of them will have directly transferred into the program area, and we have probably moved down that pathway. I can take on notice to try to give you how it all crosses over. If you look at—and you will not have this there; this is just for your reference—the portfolio budget statement of 2016-17, on page 32, it looks at the outcome structure changes. Then on page 34 it does the mapping of the 2015-16 and 2016-17 outcome and program structure. That will give you a bit of an idea of how that happens. It does not give you money; it just shows you how we have tried to track the mapping. We tried to do that. You will find that on pages 34 through to 36. It maps the old 11 outcomes and tries to deal with it in that way.

Senator DI NATALE: I would like to be clear about this. I understand the rationale and, yes, if we assume the best of intentions, then there is certainly logic to it, but obviously, if we want to take a more sceptical approach, it is an opportunity to make some significant cuts and, in our position, we are unable to track those. What I am asking on notice, very clearly—and please tell me if you cannot do this—is to not just map where each of those funds have gone,

into what outcome and exactly where they sit, but show how much they were funded in the previous financial year and how much they will be funded in the current financial year.

Mr Bowles: We probably will not be able to do that quite specifically, but, in your language—

Senator DI NATALE: Why not?

Mr Bowles: If we have taken some of the old funds, we have probably put them into three different areas—

Senator DI NATALE: So why can't you just say that?

Mr Bowles: I can take that on notice and I will explain how that happens. I just do not want to give you any false impression about it. Any cuts to the budget will be budget measures. So you will see them—irrespective. This is about trying to simplify it into the long term, to get away from this notion that everything is flexible, because they are service delivery elements of these programs.

Senator DI NATALE: When we are talking about flexible funds, how will any cuts to the budget be represented?

Mr Bowles: I think I have answered this on notice a number of times regarding the different flexible funds and budget implications. If we go back to my first estimates—which probably was MYEFO 14, I think—and look at the subsequent changes, there were changes to flexible funds.

Senator DI NATALE: Yes, but—

Mr Bowles: And I have put those all back into context.

Senator DI NATALE: I agree, but how do we represent the change from the last financial year to this financial year under the new structure?

Mr Bowles: Any changes to the budget would have come up as a budget measure at the time. I just cannot recall, off the top of my head, what ones happened in the context of 2016-17. So we will take that on notice and we will see how we can work it out. I think I understand what you are trying to say. But, because we moved from a flexible funds structure to a different outcome and program structure, does not mean that you will not see the changes; you just will not see the changes in the context of the old flexible funds.

Senator DI NATALE: I will just ask a few more pointed questions about that. Have any flexible funds that were previously funded not moved into corresponding outcomes? Have any of them been cut altogether?

Mr Bowles: They were cut up to the point in time that we had them—and that is all on the public record forever and a day. There would be questions on notice around what they were at that point in time.

Senator DI NATALE: While they existed as flexible funds?

Mr Bowles: Yes, while they existed as flexible funds. If there was money in a flexible fund it moved into the program area. There was not a process of, 'Let's move it in because we have got no money left here.'

Senator DI NATALE: That is what I am asking.

Mr Bowles: That did not happen.

Senator DI NATALE: Or was it, 'This is funded—

Mr Bowles: That does not mean that programs will not have budget implications over time.

Senator DI NATALE: I understand that.

Mr Bowles: But that will happen over time, I am sure. But it was not a process of doing this for the purpose of that. This was purely administrative to try to get a better way of managing what are program delivery funds.

Senator DI NATALE: Can you tell me whether any specific organisations or programs have actually been cut, other than the ones we were aware of at the last estimates hearing?

Mr Bowles: I do not believe there is anything other than what we would have talked about at the last estimates.

Senator DI NATALE: Could you take that on notice?

Mr Bowles: I will take that on notice. But we have not changed the world since the budget, and I cannot think of anything that would have changed since the last budget.

Senator DI NATALE: Some Indigenous programs, for example, were no longer funded. Will that continue to be the case?

Mr Bowles: I will take that on notice, but what I can say is that Indigenous funding is definitely not cut. There may be changes in programs—I cannot guarantee that—but Indigenous funding is still there and it is a growing and escalating fund.

Senator DI NATALE: I will wait until I get that information—and, hopefully, we do not get it on the morning of the next estimates hearing. It would be helpful to have this sooner rather than later.

Mr Bowles: I will definitely try, Senator. There is nothing here that I am trying to hide; I am actually trying to make it a little more visible how we actually effect programs.

Senator DI NATALE: As I said, I understand the rationale, but obviously the concern is that there could be other motives at play. I have some overall health expenditure questions. Can you give me the health expenditure for the current financial year compared to the previous financial year in total? That is a question I have asked previously at estimates.

Mr Bowles: We would have gone through this in budget, and nothing has really changed from budget. I just need to find where the overall numbers are now. We will find those for you. So you are talking about MBS and PBS?

Senator DI NATALE: Correct.

Mr Bowles: We can do the global numbers, by the looks of it.

Mr Yannopoulos: Global numbers: $89½ billion in the 2016-17 budget; $92.8 billion in 2017-18; $96.7 billion in 2018-19; and $101.2 billion in 2019-20.

Mr Bowles: And just to be clear: they are whole-of-government health related figures.

Senator DI NATALE: And what was 2015-16?

Mr Yannopoulos: It was $85.9 billion.

Senator DI NATALE: Good. And perhaps on notice, could you give me a breakdown of that?

Mr Yannopoulos: Yes, sure.

Mr Bowles: Yes. We will break down the key five or six because, literally, the majority of our health spending goes on those four, five or six items.

Senator DI NATALE: Has the department done any work at all on exploring an increase to the Medicare levy?

Mr Bowles: No, not at this particular point. We have been looking, as you would know, at a whole lot of reform activities around things like Health Care Homes—we are looking at options like that. Ultimately, revenue measures are not ours—they are a Treasury related issue. We constantly look at what the impacts of the current Medicare levy are and things like that, but that is where we are.

Senator DI NATALE: I just want to ask a quick question about—and we have had a bit of a discussion about outsourcing and the potential for contracts and so on—the National Cancer Screening Register. How is it that the department would allow the signing of a major contract without legislation having actually passed the parliament?

Mr Bowles: I suppose with the legislation of the register, we have been doing that for quite a while. There is not necessarily an expectation, because we go to the market, that we would see that as a particular issue.

Senator DI NATALE: No, you signed a major deal with Telstra. It was worth a couple of hundred million dollars and you did not have the required legislation to honour that contract.

Mr Bowles: Again, this has got very mixed up because all of a sudden there is the notion that Telstra is not appropriate, which I do not accept. I just do not accept that at all.

Senator DI NATALE: That is beside the point.

Mr Bowles: We went to the market in 2015. This was not something that was new in the marketplace.

Senator DI NATALE: But without the enabling legislation having passed the parliament. Is that unusual?

Mr Bowles: No, it is not unusual, because—

Senator DI NATALE: Can you give me other examples of that kind of action?

Mr Bowles: We have legislated registers many times before, I suppose. It is one of those things.

Senator DI NATALE: No, that is not the point. The point is actually signing a big contract worth, I think, $220 million, and not having the enabling legislation.

Mr Bowles: Ultimately, I would not have expected there to be an issue with coming up with a national register around—

Senator DI NATALE: Handing over sensitive private information when—

Mr Bowles: We are not handing over sensitive private information to anybody. That is a furphy.

Senator DI NATALE: What is Telstra using then?

Mr Bowles: Well, again—

Senator DI NATALE: Telstra has access to sensitive private information on patients. We are wondering whether this is appropriate or not.

Mr Bowles: There are a range of measures in place. We are not handing over—again, this is another one of these furphies—

Senator DI NATALE: So what are we paying Telstra $220 million for?

Mr Bowles: To run a register.

Senator DI NATALE: And what is on the register?

Mr Bowles: We do not—

Senator DI NATALE: No—what is on the register?

Mr Bowles: It is, obviously, a whole lot of information about these people.

Senator DI NATALE: Yes!

Mr Bowles: The inference of your question is that a provider in the public sector—and I just do not believe this!—cannot do the right thing around systems. That is effectively what you are saying.

Senator DI NATALE: No, no—that is not what I am saying at all—

Mr Bowles: And I do not—

Senator DI NATALE: No—please do not put words in my mouth. That is not what I am saying. I am saying that this was a very significant decision. It involved a national register, where a for-profit company was collecting sensitive information about individuals. Some of these people may have sexually transmitted diseases; let's remember that there are some forms of cancer that are linked to sexual behaviour. That—

CHAIR: Sorry to interrupt your question. I note that we will come back to this under specific outputs. I just want to—

Senator DI NATALE: I will perhaps continue that during the other outcome measure and handover to my colleague Senator Rice and then Senator Xenophon.

Senator RICE: Thank you. I have very general questions of whole of portfolio about how the department across its various programs is addressing the health needs of the LGBTI community, whether there are particular focuses, programs and analysis to ensure that programs are meeting the health needs of the LGBTI community.

Mr Bowles: You want to know how specifically we actually deal with those sorts of issues?

Senator RICE: If there are specific initiatives, particular programs or any analysis done to identify how they are particularly addressing the needs and are appropriate for the requirements of the LGBTI community.

Mr Bowles: I think there is a broad range of that we do across a whole range of different groups from disability to LGBTI to Aboriginal and Torres Strait Islander and so on. As an organisation, at one level we have established a network in all of these areas where we get these groups together and we talk about a whole range of these things. It is not only in the policy context; it is also in an organisational context because you have to deal with it in an organisational context to get your policy outcomes right. So that is where it starts.

Senator RICE: So you have an LGBTIQ focus network across the department?

Mr Bowles: Yes, we have an LGBTI network, the pride network. They meet regularly. I meet with them regularly, as I do with the disability and carers network—it is actually Carers Week this week—and also the Aboriginal and Torres Strait Islander network. We also have a group that is multicultural and we celebrate things like Harmony Day and so on and so forth. So there are all of those things that are in place in an organisational sense. Mr Stuart might be able to give you a bit more detail on quite specific areas.

Mr Stuart: What we principally do is to examine our programs to ensure that we do not have discrimination in place against any particular population group. Over the last few years, we have been paying particular attention in the areas that I look after in the MBS and the PBS to ensure that there is not discrimination in those programs in relation to any person of any particular kind of status.

Senator RICE: Anything beyond just ensuring no discrimination to actively do the analysis to ensure that the programs are tailored to meet the particular requirements and needs—for example, those at high risk of cancer through higher smoking rates, and those with higher mental health issues—to make sure that the programs are tailored to meet the needs of the LGBTI community?

Mr Stuart: The framework of the programs that I am here specifically talking about, MBS and PBS, is to make sure they are widely available to the whole population rather than being specific programs for specific people. What we have been attending to there is to ensure there is not discrimination. And, from time to time, when we receive correspondence about whether particular items should or should not be available to LGBTI people, we examine those and make sure that there is availability for those groups.

Mr Bowles: I think the important point also is that, organisationally, how we deal with these broad issues brings a cultural aspect to how we deal with things more broadly in an organisational context. We put a lot of focus and attention into these areas.

Senator RICE: Have you any examples, findings or things that have come from your pride network that have influenced program design or program approach?

Mr Bowles: Not specifically off the top of my head. We did some work recently around Wear it Purple Day and try to understand the discrimination issues not only in a health sense but in a staffing sense, and what that actually means. So there is a whole range of those sorts of things. I can take on notice to have a look at quite specific other examples where it has changed.

Senator RICE: I am particularly interested in programs where there is a lot of money being spent—for example, on cancer screening or other preventative health programs—ensuring that they are meeting the needs, particularly where you have a greater prevalence of the disease in the LGBTI community as compared with the general community. How are you ensuring that those programs are appropriately designed and targeted?

Mr Bowles: Bloodborne diseases will be one of those programs, quite specifically. We do a lot of work in that space and across the board, but particularly with LGBTI communities in mind. How we actually operate in that specific space has been an ongoing issue for many, many years now.

Senator RICE: Exactly. That is an obvious one. But there is a whole broad range of programs.

Mr Bowles: There are.

Senator RICE: Okay. Thank you.

Senator XENOPHON: I refer you, Mr Bowles, to the tabled question on notice No. 12 where I asked the minister for health what the total legal cost had been in the investor-state dispute arbitration conducted under the United Nations Commission on International Trade Law Arbitration Rules in relation to tobacco plain packaging. Are you familiar with that?

Mr Bowles: I am just trying to find it.

Senator XENOPHON: It was question on notice No. 12 dated 30 August 2016.

Mr Bowles: Was that an estimates question on notice?

Senator XENOPHON: No. It was a Senate question. We do ask them on notice in the Senate.

Mr Bowles: I understand that; I just do not have that to hand.

Senator XENOPHON: It is a very good mechanism. Let me help you. The due date for tabling is headed as 29 September 2016. I asked questions, essentially, about how much money has the Australian government spent in dealing with the investor-state dispute arbitration in relation to the plain packaging case that was conducted in Hong Kong. Are you familiar with that case?

Mr Bowles: I am.

Senator XENOPHON: The response, via Senator Nash on behalf of the minister for health, was that the Australian government does not disclose figures associated with defending these legal actions as public disclosure of that information may confer a tactical advantage on other parties to the litigation, and it said that it is cabinet in confidence—confidential to cabinet. Is that still the position of the Australian government in respect of that?

Mr Bowles: Yes, it is.

Senator XENOPHON: It is. So is it safe to assume that lawyers for the department were in a contract that required them to tender invoices at particular intervals?

Mr Bowles: I cannot go to the specifics, but that would be the normal process.

Senator XENOPHON: Let me help you. You retain lawyers because they send you invoices.

Mr Bowles: Yes. That would be the normal process.

Senator XENOPHON: Most lawyers do not tend to work for free.

Mr Bowles: That is correct. And, yes, we would have paid them, but—

Senator XENOPHON: You would have paid them on invoices?

Mr Bowles: I would imagine that would be the normal way we would do things.

Senator XENOPHON: I am just trying to work out the normal way in terms of how you do things. Would it be reasonable to presume that the dominant purpose for the generation

and tendering of those documents to the department would be to get paid for the services listed on the invoice?

Mr Bowles: I imagine that would be the normal way to do things, yes.

Senator XENOPHON: That is the dominant purpose. And I presume the department paid those invoices.

Mr Bowles: That would be correct. We pay our bills, yes.

Senator XENOPHON: Are you aware that the fundamental test, the essential precondition, with respect to a document which attracts a claim of cabinet in confidence is that at the time of its inception the dominant purpose of that document must be for submission to cabinet? Clearly that was not the case here. Clearly cabinet did not have a say that the mere fact of invoices being tendered was itself a matter that cabinet should keep in confidence.

Mr Bowles: The whole investor-state dispute is a matter that was of interest. If we were to pay the bills we would have had to get funding for the bills. Therefore, it goes to ERC, which is a cabinet process.

Senator XENOPHON: Let me explain to you what has got my back up in terms of a lack of transparency. This was a major piece of litigation.

Mr Bowles: It was.

Senator XENOPHON: It raises broad issues about this investor-state dispute resolution clause, of which I think Senator Di Natale shares common concerns. I want to make it absolutely clear, so there is no misunderstanding, that I was a strong supporter of the plain package legislation and the fact that the Australian government had to defend it, even though it was a rather bizarre set of proceedings issued.

Mr Bowles: It was.

Senator XENOPHON: I think there was a lot of cheek on the part of the tobacco company involved. Well, 'cheek' is a very mild word. I think it was an outrageous act. So you are saying that the claim of cabinet in confidence has been based on legal advice to the department. Is that right?

Dr Southern: The matter of costs in this particular case is still the subject of litigation that has not been finalised yet, so we currently have submissions before the tribunal in relation to settling costs. If you go back to budget papers which relate to the funding that the department has for these cases, they are always listed as 'not for publication'. The main reason being in relation to not giving an advantage to the opposition in this particular case.

Senator XENOPHON: You are talking to an old litigator here—more of an ambulance chaser, I should say.

Dr Southern: I would never say that.

Senator XENOPHON: I can. How do you give a tactical advantage to the other side about how much money you have spent on legal costs?

Dr Southern: I think it goes to what services and expertise the Commonwealth might have been buying in relation to this case.

Senator XENOPHON: The Senate has a fundamental appropriation oversight responsibility in terms of how taxpayers' money is being spent and how much is being spent. I

would have thought access to that cost information would be relevant for a whole range of reasons, including for the broader debate about how expensive and how problematic these investor-state dispute resolution clauses can be.

There is an FOI decision where the total cost of litigation is not exempt. It is called the Sweeney and Australian Securities and Investments Commission 2013 decision, handed down 30 August 2013. In that decision the AAT disclosed that the documents would not reveal the hourly or daily rate charged by counsel—I am paraphrasing here—and, even if disclosure would reveal that information, its commercial value could not reasonably be expected to be destroyed or diminished by that disclosure. Has the department considered Sweeney's case in the context of what I consider to be an outrageous use of the cabinet in confidence excuse not to disclose how much has been spent in this litigation?

Mr Bowles: In an effort to be helpful here: we are trying to claim costs against the company. That is part of the issue that we are dealing with here.

Senator XENOPHON: And?

Mr Bowles: And we do not want to show our hand about a whole range of things. That is why it goes in the budget papers as 'not for publication'.

Senator XENOPHON: The invoices were paid, were they not?

Mr Bowles: There are two issues at play—two separate issues. Yes, we get invoiced and we will pay a bill. We won that particular case and that was, from our perspective, absolutely the right outcome. We are now in a process to claim costs against the company. In an effort to be helpful, once we have settled that I will revisit your question to see if we have an option around giving you more visibility of that once we have finished that particular case.

Senator XENOPHON: Thank you. I might end up seeing you in the AAT, but thank you.

Proceedings suspended from 10:32 to 10:45

CHAIR: We continue on whole-of-portfolio corporate matters, and I will hand now to Senator Lines.

Senator LINES: Mr Bowles, it was very disturbing to receive answers to questions on notice at 9 am today. These were questions that we put on notice after the last estimates. I want you to explain to the committee, first of all, why it has taken months and months to get fairly basic information. So the questions we got—do you need me to go to them?

Senator Nash interjecting—

Senator LINES: The first one was reference No. SQ16-000362. It was about individual health benefits in relation to the Child Dental Benefits Schedule. The second one was access to mental and dental services, and that was reference No. SQ16-000071. It was regarding Medicare bulk-billing across the country.

Mr Bowles: Yes, I understand they were tabled this morning.

Senator LINES: I am asking you why it has taken such a significant amount of time to basically get information that—the first one was in relation to Medicare and was compiled out of Commonwealth electoral divisions and the second one was in relation to cuts to the Child Dental Benefits Schedule, so not complex questions. I am just asking what the reason was that we got them at 9 am.

Mr Bowles: I beg to differ, because some of these are complex questions and they are complex to put together in a way that makes sense. We do not generally hold things by electorate details, for starters. We obviously have given you that. We have given it in the past in different ways. We were trying to make sure we got that right. It is there. As for the dental one, there is complexity to that. The reality is we did get the majority of our answers to questions on notice in on time or nearly on time, and there were a few that were outstanding. They have been worked through and they are in today.

Senator LINES: So where is the complexity in the Child Dental Benefits Schedule question? Senator Gallagher was asking what the savings were in that program. We are talking about two programs—the national partnership agreement and the Child Dental Benefits Schedule.

Mr Bowles: The complexity lies in the fact that there are two programs and they are demand programs. They were not meeting their demand, if you like, and we had to look at how we actually structured those programs. We were in the process of—

Senator LINES: Mr Bowles, we did not ask about that. What we asked you to identify for us was what the savings were.

Mr Bowles: And I am explaining to you that to come up with that answer we have to work through all of those particular processes. This comes in the context of the new Child and Adult Public Dental Scheme that was in the budget, and it was about closing those two programs and moving it into that. As we know at this stage the extent—

Senator LINES: And you gave us that information at last Senate estimates. I appreciate most of your answers you get in on time, but I simply make the point: to give us answers to questions, particularly in relation to the Child Dental Benefits Schedule, today is unacceptable. Nevertheless, I just want to make sure now that we understand the answers you have given us. You are saying that one of the savings comes from the transfer of national partnership agreement moneys into the Child Dental Benefits Schedule?

Mr Bowles: Sorry, I missed that; someone was talking.

Senator LINES: You are saying that one of the savings comes from the transfer of $155 million over three years, so that is $465 million. You are transferring that from the NPA, the national partnership agreement, to the Child Dental Benefits Schedule?

Mr Bowles: No, to the Child and Adult Public Dental Scheme, which was the new scheme in the budget.

Senator LINES: I beg your pardon; my mistake. Yes, you are transferring that to CAPDS.

Mr Bowles: Yes.

Senator LINES: And then, in addition to that, you are projecting a saving, because of what you say is a low take-up rate, of $1.3 billion over the forward estimates?

Mr Bowles: That is correct. The child dental benefits scheme has been running for a number of years, and it is run at a certain level. The new adult public dental scheme going forward, we were looking at funding that was being spent in that program, tipping that into the broader new program, the CA—whatever the acronym for that adult public dental scheme is.

Senator LINES: Yes. So the total savings then are the $1.3 billion you have identified?

Mr Bowles: Yes.

Senator LINES: And the 465 million you have identified.

Mr Bowles: Yes. The 1.3 identified is the money that has never been spent on dental. It was there in a budget context, but never spent because the program never ever met its demand levels, if you like.

Senator LINES: Thank you, Mr Bowles, and we hope that you will not be tardy with the questions that will come out of here.

Mr Bowles: I appreciate that, Senator. We do try, and generally speaking we are pretty good at getting our answers back. We always have a few that are difficult and that I ponder over for a period of time. I accept that. But we have got them in ultimately, Senator; that is a positive.

Senator POLLEY: I would like to raise the issue about the measures in the 2015-16 MYEFO delivering cuts of $472 million to the aged care funding instrument over the forwards and measures in the 2016-17 budget delivering cuts of $1.2 billion. Is that correct?

Mr Bowles: Do you want to deal with that now—

Senator POLLEY: Yes.

Mr Bowles: or in the outcome areas? So you want to do it in whole of portfolio?

Senator POLLEY: We are dealing with that now, yes.

Senator SMITH: Point of order, Chair: there might be other senators who are expecting to—

Senator POLLEY: We are coming back to that as well, but I have some questions that I want to ask now. We will be going through it—

Senator SMITH: So you are going to ask them now and—

Senator POLLEY: I will not be asking the same questions again, but we will be visiting—

Mr Bowles: It is a program area; it is not a whole-of-portfolio area is my point, Senator.

Senator POLLEY: Yes, we would very much appreciate being able to deal with these. There are only a few questions that we will deal with here, and then I intend to go to another area so that we can wind this up.

Mr Bowles: If I could just make a point, Chair: we structure the day so that I can have my officers here. We are a very complex organisation.

Senator POLLEY: I appreciate that.

Mr Bowles: I appreciate where the senator is coming from. We will endeavour to try to answer a few here, but if we can stick to the program areas it would be appreciated.

Senator POLLEY: I think Dr McCarthy is able to respond to all of these.

CHAIR: Secretary, I would like to seek some advice: are you saying that your officers are not here to provide the answers?

Mr Bowles: We can do some of it now, but we have got the majority of our aged care people coming whenever aged care is on the agenda. I do not have it in front of me at the moment. Dr McCarthy is here. We will see if we can answer a couple of questions in this

space, but if we can hold the majority of aged care questions until the appropriate time that would be appreciated.

Senator POLLEY: We will be doing that.

CHAIR: I appreciate that. As soon as it becomes a point where you require other officers, I am sure other senators would agree that we should defer to the relevant spot. But we will proceed with a few questions.

Senator POLLEY: Absolutely, but the whole of government has been the normal practice—

Senator SMITH: Excuse me, Chair, just for the record, Senator Polley—

Senator POLLEY: Chair, I had the call.

Senator SMITH: No, a point of order: just to be clear—

Senator POLLEY: I had the call!

Senator SMITH: This will not disadvantage you. I just want it recorded that on this occasion coalition senators are happy to accommodate you, but not if this is going to be a precedent for the way that opposition senators manage their time in future Senate estimates.

Senator POLLEY: I would like to address the point of order. This committee has, for the last 12 years, been very flexible in dealing with outcomes—

Senator SMITH: You have not been on the committee for 12 years, Senator Polley.

Senator POLLEY: I had the call, Chair, so we are wasting time that is valuable.

CHAIR: We are, yes.

Senator SMITH: I just had that recorded, Chair.

Senator POLLEY: My question is—

CHAIR: Sorry, Senator Siewert, did you have a comment?

Senator SIEWERT: My concern is this: I expected this to be on under the aged care provisions. I am next door as well; I am juggling two committees, as are others, so if this is an extensive travail of this issue—

Senator POLLEY: It is not. I have four questions.

Senator Nash: I just want to make a general point on the effective use of time. Senator Siewert's observation is a very good one. We have things designated for a certain program area and if we bring them up earlier in the day we end up having the same questions asked again by a different senator who was not in the room at the time and they are not able to follow the trail of questions.

Senator POLLEY: That happens anyway.

Senator Lines interjecting—

Senator POLLEY: We can have a private meeting. If it means we have a private meeting—

Senator Smith interjecting—

Senator Lines interjecting—

Senator Nash interjecting—

CHAIR: Okay, Senators, order! I bring the committee back to order. We may as well have a private meeting, just to resolve this.

Proceedings suspended from 10:54 to 11:02

CHAIR: The committee will reconvene and Senator Polley will continue with other questions while we await a ruling from the Clerk on the ACFI questions.

Senator POLLEY: My questions now refer to whether or not the department has contracted or considered contracting any aged-care services that help older Australia navigate the aged-care system.

Mr Bowles: We are into aged care again—that is not really a whole-of-portfolio issue. I only have a couple of people here, and they will not know everything about aged care.

CHAIR: Senator Polley, do these questions fit under the same group that we are awaiting a ruling from the Clerk on? Do you have others that you could move on to, just for the sake of clarity?

Senator POLLEY: Maybe you can answer this question while we are seeking the Clerk's advice. I need your clarification as to whether the department engaged or contracted any similar services to assist consumers with navigating and preparation for their Home Care Package reforms? Are you saying that you want all of these questions this afternoon?

Mr Bowles: Yes.

CHAIR: That is in the spirit of what we just discussed in the private meeting.

Mr Bowles: I am happy to go to all of these things, but we do not necessarily have everyone here and Dr McCarthy and Dr Hartland will not have everything.

Senator REYNOLDS: Excuse me, Chair, I have a point of order. We have just had a private meeting and we agreed that all those questions relating to aged care will be postponed until we get the ruling from the Clerk on the issue. I think our discussions were quite clear.

CHAIR: Senator Polley, you indicated in the private meeting that you have other issues that you want to go on to?

Senator POLLEY: Yes, they were the questions relating to corporate and contracts that I wanted to ask, and also the ACFI questions. We will have to wait until the Clerk's ruling.

Senator MOORE: Mr Bowles, I spoke with you briefly before. I am wanting to find out what the department's engagement is with the full national response to the sustainability goals.

Mr Bowles: I will see if Mr Cormack can help me on this. This goes across a whole range of different areas of the department.

Senator MOORE: Absolutely.

Mr Bowles: It probably does fit here more than anywhere.

Senator MOORE: If there is something that needs to go on notice that is fine as well. I understand that the position is that the Department of Foreign Affairs and Trade is leading the government's response—

Mr Bowles: That is correct.

Senator MOORE: but they formed an interdepartmental committee. I am really keen to know whether Health are on it. I presume they are. Who is going and what do they see their role as being?

Mr Bowles: As you say, Foreign Affairs and Trade are the lead. We get engaged from time to time. As you said, there is some whole-of-government stuff that happens in the background. I am not sure if we will have the answers for your specific questions around that. We can take that on notice.

Senator MOORE: Sure.

Mr Bowles: It does come up in a broader international context as well through the WHA, the World Health Assembly. These are issues of global significance. So we are engaged quite heavily during that World Health Assembly time. Effectively DFAT run the agenda from there. I do not know if Mr Williams can assist any further on that.

Mr Williams: Yes, I can. Sorry, can I get clarification of the question.

Senator MOORE: Mr Williams, I am asking across a range of departments about the government's response to the sustainable development goals and which departments are involved and at what level. Because of the department's domestic as well as international responsibilities now, is there a process being put in place so that the department are looking at their own work through the events of the SDGs?

Mr Williams: There is an IDC being hosted by DFAT and PM&C, as you recognised, with 17 departments currently attending. We are looking internally at our options. The first meeting was held on 14 September, as you are probably aware.

Senator MOORE: Yes.

Mr Williams: We expect that IDC to meet regularly. During the 14 September meeting it was agreed that the 2030 agenda take the following actions. We are going to map the existing government work that supports the 2030 agenda domestically and develop a whole-of-government narrative in response to that.

Mr Bowles: It would be best to talk to DFAT about the outcomes.

Senator MOORE: Absolutely. I understand that. I will be talking to DFAT tomorrow. There are two reasons I am particularly talking to Health. One is the issues domestically which we now have to report on. That is a totally new agenda. The second is Health's ongoing engagement internationally. Already through a number of programs Health has been the lead agency in that space. Basically, Mr Williams, rather than taking all of your time, could we get a departmental response on notice on what has been Health's role?

Mr Williams: Of course.

Senator MOORE: Can it particularly be in view of the way ongoing work now needs to be mapped against the SDGs into the new line of inquiry? If I could get that back, that would be wonderful.

Mr Bowles: Yes, we can take that on notice.

Senator MOORE: I have another question in the same area to the chief medical officer. Welcome, Professor Murphy, and congratulations. Is this your first estimates?

Prof. Murphy: I have been in the role three weeks.

Senator MOORE: You will get this one easily. The World Health Organization released their report on tuberculosis last week. Whilst luckily we are not one of the listed countries, a lot of our near neighbours are. The WHO made a couple of statements in that report about the vulnerabilities with TB of other conditions, one of which is diabetes. That was particularly interesting since we have a national diabetes strategy. This may need to be taken on notice. Could I get some information around how that international TB position links in with our ongoing strategy, particularly around diabetes. That was something I was unaware of until I saw this report. Minister, I was wanting to see whether I could get a briefing—and I wanted to put that on record during the estimates process—about the whole TB position.

Senator Nash: I am very happy to ask the minister for that.

Prof Murphy: Thank you, Senator Moore—we will take that on notice. Our biggest problem with TB is in the Indigenous population, and that is, obviously, where we are focusing. We are happy to provide some data on the relationship with diabetes.

Senator MOORE: That would be great. Thank you very much.

[11:10]

CHAIR: We shall now move on to outcome 4.

Senator POLLEY: The day before the election, the Prime Minister guaranteed that Australians would not pay more to see their doctor as a result of the freeze. We did talk about this earlier, and you said that is government policy and you cannot give any guarantee other than what government policy is. Is that correct?

Mr Bowles: In relation to the freeze, I said it is current government policy—that is correct.

Senator POLLEY: So, obviously, you are not disagreeing with the Prime Minister that there is a guarantee to the community that they will not be paying any more?

Mr Bowles: I am not going into what the Prime Minister has said; I am talking about the current government policy position on the freeze. I think what we look at in this context are bulk-billing rates and out-of-pocket expenses.

Senator POLLEY: Did you give the Prime Minister any information that supported his guarantee?

Mr Bowles: The minister is my line, if you like—I do not give things directly to the Prime Minister. Clearly the whole issue of bulk-billing rates and out-of-pocket costs for doctors—ultimately doctors are in charge of what they do. I think the Prime Minister has made that point very clear. I think his link was that the freeze does not link directly to an increase in doctors' wages. I know there is a range of media commentary around that—I am not going to go into the media commentary. We can talk about what we see as the impacts around bulk-billing rates of these sorts of issues.

Senator POLLEY: Is the department aware whether or not any doctors or practices have stopped bulk-billing as a result of the freeze?

Mr Bowles: I personally do not know of any, and, again, we will look at the system and all the doctors, if you like, and we will notice what happens in the context of bulk-billing rates. We can talk about those, if you like. Mr Stuart can talk about the changes in bulk-billing rates.

Senator POLLEY: That is actually not what I am asking.

Mr Bowles: But those are the things that I can answer.

Senator POLLEY: So the department is not aware of any doctors in the country—or their practices—who have stopped bulk-billing because of the freeze? I want to make that very clear. I am not talking about bulk-billing numbers; I am talking about whether they have stopped bulk-billing.

Mr Bowles: The only way we can really give you a proper answer is to give you the bulk-billing rates. I am sure doctors across this country start and stop all the time—and they do—but the only way we can give you an answer to your question is to talk about what is happening with bulk-billing rates on a national basis.

Senator POLLEY: If you have those figures, you can table those and then we will take those—

CHAIR: The secretary will provide an answer how he feels he can. Secretary, please answer the senator's question.

Mr Bowles: Again, going to this issue, bulk-billing rates are the way we will look at what is actually happening in the broader national health system. That is the way we look at that. We can talk about that—

Senator POLLEY: Has there been a decrease?

Mr Bowles: No.

Mr Stuart: There has been a continuing increase in bulk-billing rates. Bulk-billing rates for general practice currently stand at 85.1 per cent, and that is actually an all-time high in terms of bulk-billing rates in Australia.

Senator DI NATALE: Following up on that, it makes sense for us to interrogate that, now that we have that data.

Senator POLLEY: It would be nice if I had the opportunity to do that.

Senator DI NATALE: Fire away—I thought you were not interested in that.

Senator POLLEY: In terms of those bulk billing rates, how is that figure broken down? Can you give me a bit more information. You are using that as justification that there has been no decrease at all?

Mr Bowles: No. We are looking at a national health system. As I said, there will be ups and downs, and people make decisions for a whole range of reasons. Doctors are largely private individuals and private business people, so they will make their decisions. How we look at this from a national perspective is that we look at the bulk-billing rates to see what the impacts are in those rates. As Mr Stuart said, it is sitting at 85.1 per cent at the moment, and that is an increase on where it has been.

Senator POLLEY: Can you give us, then, the breakdown of the states and the bulk-billing rates for each state.

Mr Stuart: Senator, I do not know if we have that here. We can do that on notice. What I can tell you is that bulk-billing rates for general practice are above 80 per cent for metro, outer metro, rural and remote. In each case, the bulk-billing rate is above 80 per cent on average across the country in all those different kinds of areas.

CHAIR: Those figures that you were going to take on notice: do you think there is a possibility we might be able to have those later today?

Mr Stuart: By state?

CHAIR: Yes.

Mr Stuart: Yes. Sorry—we do have something for 2015-16.

Ms Jolly: I have a table here which is the MBS bulk-billing rate for GP attendances, which excludes practice nurse items, by financial year. Overall, as Mr Stuart indicated, it is 85.1 per cent. In New South Wales, it is 88.6 per cent; in Victoria, 84.8 per cent; in Queensland, 84.5 per cent; in South Australia, 84 per cent; in Western Australia, 80.1 per cent; in Tasmania, 76.7 per cent; in the Northern Territory, 87.4 per cent; and in the ACT, 60 per cent.

Senator WATT: Is that actual services or patients?

Ms Jolly: That is the percentage of GP attendances that are bulk-billed.

Mr Bowles: So, services.

Senator POLLEY: So, they are for services not for patients?

Ms Jolly: Yes—services

Mr Bowles: If you look at the longitudinal way we have looked at this, we look at services in this space.

Senator DI NATALE: Do you have data on patients?

Mr Stuart: We have some data. It is a much more complex picture. As you would be aware, there will be patients who are bulk-billed all the time; there will be patients who are bulk-billed a lot of the time but not always; there will be patients who are bulk-billed some of the time; and there will be some patients, who may have only had one or two services, who are never bulk-billed. So, in terms of types of patients, patients are more likely to be bulk-billed if they have more services in a year; they are more likely to be bulk-billed if they are concessional or older or children. The bulk-billing rates for all of those kinds of groups are higher than the average. Clearly, what doctors do is they discriminate in terms of who comes into their practices according to their view about the needs of patients. The great majority of patients are bulk-billed the great majority of the time, and that is what is reflected in the 85.1 per cent.

Senator DI NATALE: So, I just want—

CHAIR: Senator Polley has the call, sorry.

Senator DI NATALE: Okay. All right. We can do it this way. We have not done it this way before. We have actually tried to tease out information. But, Senator Polley, if you want to go ahead—

Senator POLLEY: Absolutely. You said that the bulk-billing rate was 80 per cent or above. In Tasmania, quite clearly, it is below; it is 76 per cent. You should, I would have thought, with these statistics, be able to give us the percentage of patients who are bulk-billed and how often they are. Can you share that sort of information with us.

Mr Bowles: First a clarification: Mr Stuart was talking about metropolitan, outer metropolitan, rural and regional and remote. He did not talk about states in that first context. He was talking about across the country, and—

Senator POLLEY: Overall—I do understand that.

Mr Bowles: they were above 80 per cent.

Senator POLLEY: But, when we went through the states, Tasmania was clearly lower—

Mr Bowles: Tasmania was marginally below it, yes.

Senator POLLEY: which is an issue, considering that our economic picture is much lower than some other states. So can you share with us, then, the percentage of patients who are bulk-billed by their GP, please.

Mr Bowles: Again, I think, Senator, it is about the services that we mainly longitudinally track. We can give a mixed picture of some of the patient-related issues. But, of the 385 million transactions that go through MBS, 85.1 per cent of those transactions—or those services, effectively—are bulk-billed.

Senator POLLEY: Yes.

Mr Bowles: I think it might be a little bit of a complex picture to go to patients, but Mr Stuart did say that the bulk of patients and the bulk of however he described that before are bulk-billed.

Senator POLLEY: Yes. So would you be able to then take it on notice to provide that information.

Mr Bowles: Yes, we can take it on notice and see what we can provide.

Senator POLLEY: The royal college of GPs says that just 69 per cent of patients are bulk-billed. So, from what your evidence today—

Mr Stuart: That is actually incorrect, Senator.

Senator POLLEY: You are disagreeing with that? You know that?

Senator DI NATALE: Why do you have to take it on notice? You have the information in front of you, Mr Stuart. Can you just provide us with the information.

Mr Stuart: No. I do not have the precise information that was asked for. But I can categorically say that more than 69 per cent of patients are bulk-billed. What I believe is being counted there is the proportion of patients that are bulk-billed every time they see the doctor. What that does not count is a range of instances of bulk-billing that take place for patients that are bulk-billed some of the time and not bulk-billed at other times. So we are not counting particular instances of bulk-billing, whereas the 85.1 per cent tells us, of every visit to the doctor, what proportion are bulk-billed patients—and that is 85.1 per cent.

Mr Bowles: If I can give a personal example, Senator: I go to my GP and, generally speaking, I pay above the bulk-billed rate. But every now and again, if I go in for a script, he will just bulk-bill me because I am in there for 2½ minutes. That is the complexity—so I would actually be a patient who is bulk-billed. So it is services that actually matter when you are trying to understand this.

Senator POLLEY: Well, from your point of view it might be services, but from a patient's point of view, if you are looking at Tasmania or WA and the ACT, it is the

community who have issues about not having access to bulk-billing. If you are saying that the college of GPs is wrong, then, quite clearly, you must be able to give us the figures that you say they are not including.

Mr Bowles: We said we would take that on notice. But we want to be clear that the cleanest way to understand is if we were seeing a drop-off in bulk-billing rates—your example; we could probably explore that a little bit further—but we are not. We are actually still seeing an increase in bulk-billing of services in this country. Again, if I use my example, I would be ticked as a patient who has been bulk-billed, or I will be crossed off because I am not bulk-billed all the time, even though I am bulk-billed some of the time. I think that is Mr Stuart's point. We will take it on notice and will try and come up with that picture for you. But it is not as clean and it is not as true as understanding the services that are bulk-billed.

Senator POLLEY: In the instances of WA and Tasmania and the ACT, have those figures decreased?

Ms Jolly: Could you just remind me of the states that you are interested in.

Senator POLLEY: Tasmania, WA and the ACT.

Senator REYNOLDS: In fact, if they could give a complete list. Maybe you could go through all of them, Ms Jolly.

Ms Jolly: Yes, sure. In New South Wales compared to 2014-15—

Senator POLLEY: If we could start with Tasmania, the ACT and WA, please.

Ms Jolly: Tasmania has had an increase from last year.

Senator POLLEY: What was the increase?

Ms Jolly: The Northern Territory—

Senator POLLEY: What was the increase?

Ms Jolly: My apologies; I am reading the wrong state. I will start that again. With 2014-15 as the comparison year, for the ACT it was 57.9 and it is now 60 per cent; for the Northern Territory it was 84.5 and it is now—

Senator POLLEY: Sorry, I just want ACT, Tasmania and WA.

Mr Bowles: It is easier to just read the list, Senator.

Ms Jolly: For the Northern Territory it was 84.5 in 2014-15 and is now 87.4; for Tasmania it was 77.3 in 2014-15 and is now 76.7.

Senator POLLEY: So it is a decrease.

Ms Jolly: In Western Australia it was 77.8 in 2014-15 and is now 80.1; in South Australia it was 83.3 in 2014-15 and is now 84; in Queensland it was 83.7 in 2014-15 and is now 84.5; in Victoria it was 84 in 2014-15 and is now 84.8; in New South Wales it was 88.2 in 2014-15 and is now 88.6; and nationally in 2014-15 it was 84.3 and is now 85.1.

Senator POLLEY: When you are gathering this information in relation to bulk-billing, do you track the different items, such as 23 or a standard consultation, that relates to the whole issue of bulk-billing?

Mr Stuart: The department's data collection comes from the Department of Human Services. It provides data in respect of every visit by every individual to every doctor. The

data can, therefore, in theory, be broken down in a very wide variety of ways, including, potentially, in principle, by the different kinds of consultation items. But we do not usually do that and we do not usually publish that.

Mr Bowles: That would be a complex job for us to do and we do not own the data; it is Human Services'.

Senator POLLEY: Before I move on, Richard, did you want to do any more follow-up on that?

Senator DI NATALE: Do you have any information right now about the percentage of patients who are always bulk-billed?

Mr Stuart: No, I do not have that with me here.

Senator DI NATALE: Do you have any information about the percentage of patients who are never bulk-billed?

Mr Stuart: No, I do not have that either.

Senator DI NATALE: If you could take that information on notice. I have information relating to out-of-pocket costs that follows on from the bulk-billing discussion. Are you happy for me to proceed? It is part of the same discussion.

Senator POLLEY: It is the same discussion. I have questions but you can go on.

Senator WILLIAMS: Chair, I have to head to Economics pretty soon. I have two minutes of questioning if I could at some stage do that.

Senator DI NATALE: How about I finish this bit off?

CHAIR: Then we can go to Senator Williams for his two minutes and then back to Senator Polley.

Senator DI NATALE: If you look at the department's Medicare statistics from 2011-12 and you look at out-of-pocket costs, it has been trending down. 2015-16 was the first year where out-of-pocket costs rose reasonably sharply. Do you have that information?

Mr Stuart: It would be good to know what specific piece of information you are referring to.

Senator DI NATALE: It is the Department of Health's Medicare statistics table 1.5A 2015-16.

Mr Bowles: Where was that, Senator?

Senator DI NATALE: What do you mean?

Mr Bowles: Where does that table come from? What it in the PBS?

Senator DI NATALE: I do not know. It is MBS data. I cannot tell you exactly the source of it. Where is out-of-pocket cost information normally kept?

Ms Jolly: I have out-of-pocket information; I am just not sure whether the table I have is the same table. The data will be the same but I am not sure whether the format I have is the same.

Senator DI NATALE: There has been a decrease in out-of-pocket costs in 2011-12, 2012-13, 2013-14 and 2014-15, but then in 2015-16 there was a significant increase in out-of-pocket costs.

Mr Stuart: Senator, that does not ring true with our data. What we have seen, commenting on the GP area in particular, is that over time less and less people are paying out-of-pocket costs as a result of bulk-billing rises, but for those that are paying out-of-pocket costs there has been a trend of increase in out-of-pocket costs over a decade now.

Senator DI NATALE: For general practice services?

Mr Stuart: Yes.

Senator DI NATALE: That is inconsistent with the data I have, so I need to go back. You are confident of that information?

Mr Stuart: Absolutely, yes.

Senator DI NATALE: The quantum of out-of-pocket costs for general practice services has been declining until 2015-16. We are not talking about absolute numbers; we are talking about the cost.

Mr Stuart: That is right—the dollar cost, both in real terms and in nominal prices. What I am talking about is, for those that pay an out-of-pocket cost, 'what is their average out-of-pocket cost'? and that has been steadily rising over the last decade.

Senator DI NATALE: Okay. I will go back and come back to you after this session. Can I ask you then, based on your data, what has been the increase in out-of-pocket costs this year compared to the previous year? And how does that compare with overall trends?

Mr Stuart: I have got some data here on inconstant prices. Starting in 2006-07, the percentage increases each year in out-of-pocket costs for GPs have been: 17 per cent; 16 per cent; 11 per cent—I am becoming more and more recent here—12 per cent in 2009-10; 11.3 per cent in 2010-11; eight per cent in 2011-12; 8.6 in 2012-13; nine per cent in 2013-14; five per cent in 2014-15; and 7.6 per cent in 2015-16.

Senator DI NATALE: Okay. Let's go from 2011-12. What did you say there?

Mr Stuart: 8.1.

Senator DI NATALE: And then 2012-13?

Mr Stuart: 8.6.

Senator DI NATALE: And then 13-14?

Mr Stuart: Nine per cent.

Senator DI NATALE: Okay. They are very different numbers to the numbers I have so I am—

Mr Stuart: This is inconstant prices.

Senator DI NATALE: I am talking about general practice out-of-pocket costs, increases adjusted for inflation, which sounds to me like the same.

Mr Stuart: Yes.

Senator DI NATALE: So we need to double-check that. So the 2015-16 increase was?

Mr Stuart: 7.6.

Senator DI NATALE: So pretty consistent in the most recent year with previous years?

Mr Stuart: Yes.

Senator DI NATALE: Okay. Good.

Mr Stuart: In fact, probably historically the numbers—the proportions were higher in the earlier part of the decade.

Senator DI NATALE: Yes. Again, we will see if we can cross-check that again. Thank you. I am done on that specific bit of information.

CHAIR: Thank you.

Senator POLLEY: I've just got some on bulk-billing as well.

CHAIR: We did talk about Senator Williams, sorry.

Senator POLLEY: Sorry, Senator Williams. I forgot about you, sorry.

Senator WILLIAMS: I will try and get my words around this. I am in receipt of an email from a doctor Al Burns, an orthopedic surgeon based in Canberra. He says: 'The proposed changes to MBS numbers for arthroscopic femoroacetabular impingement'—does anyone know what that is?

Ms Jolly: Yes, I do, Senator.

Senator WILLIAMS: Would you like to come forward. FAI.

Mr Bowles: We can ask the Chief Medical Officer.

Senator WILLIAMS: Dr Burns says this will have a significant effect on young people with hip pain who he treats. 'The very specialised surgery which has been made possible by recent advances in medical technology has the ability to reverse these FAI changes—improve symptoms, quality of life et cetera.' Now what he is saying is these surgeons will now have restricted access to Medicare benefits for services they currently provide—they are saying, I think, it is 1 November this comes into place—as a recommendation by MSAC. The ball or the socket—young person might be 14-years-old, been playing football. They can do keyhole surgery, fix them up. It says, 'keyhole surgery for FAI is an internationally recognised and widely utilised procedure with significant literature in peer reviewed journals'. They are saying, if you are going to restrict these keyhole surgery operations going ahead, then sooner rather than later they will have to have a total hip replacement, which is a $30,000, $40,000, $50,000 operation. Can you explain, Ms Ryan, what the story is here?

Ms Ryan: This is a decision arising from MSAC—you are correct—and the issue of the relationship between this service no longer being Commonwealth supported and a later increase in hip replacements was not borne out in the evidence. So this was a direct issue raised with the MSAC.

Senator WILLIAMS: Just repeat what you said then, please.

Ms Ryan: That statement that you made refers to—

Senator WILLIAMS: In other words, having an FAI keyhole surgery prevents hip replacements?

Ms Ryan: Yes. That was an issue examined by MSAC and was not one that they were convinced of, nor which the evidence supported.

Senator WILLIAMS: So 'the doctors are wrong' is what they are saying.

Mr Bowles: It is not what the evidence says anyhow.

Senator WILLIAMS: Dr O'Sullivan has written to me about this very issue. I know Dr O'Sullivan, he replaced my hip a couple of years ago, a very good surgeon. He says: 'At the

very least I believe that a review of the MSAC decision or a delay in the implementation of it should occur so that we can continue to offer our patients the best possible outcomes'. So the orthopedic surgeons, who have plenty of work on, as you know, are saying that this is a good procedure and that it is going to be costly in the long run because more people are going to have to have hip replacements.

Mr Bowles: We use MSAC, which is the Medical Services Advisory Committee—

Senator WILLIAMS: Created in 96, I think.

Mr Bowles: quite deliberately as an independent group that actually look at the activity, and their assessment is that those two things do not go together the way it is described in that letter.

Senator WILLIAMS: So how do I go about perhaps asking MSAC to perhaps have a closer look or work with these doctors to review their decision? Is that possible?

Ms Ryan: Senator, in relation to this issue, the Australian Orthopaedic Association did put a strong rebuttal to MSAC. Notwithstanding the government's decision about these changes—and these changes are scheduled to commence 1 November—last month Robyn Ward and the executive of the MSAC considered the rebuttal and still came to the same conclusion.

Senator WILLIAMS: I have been talking to Minister Ley's office about it, so I will have more discussion with them to see if this is the right decision; because, if it is the wrong decision, the costs in the long run are going to be more expensive for the taxpayer than this procedure going forward—and hopefully saving premature hip replacements. So I will take it up with the minister's office. Thanks, Chair.

CHAIR: Thanks, Senator Williams. Senator Polley.

Senator POLLEY: Thank you very much. I am just wondering if we can go back to the bulk-billing figures. I am asking whether you could give me the figures or the bulk-billing rate for under-23 as at June this year. That is pretty standard. That is a standard figure, so you would be able to provide that to me, please?

Mr Bowles: We will not be able to provide specifics down to an item. We talked about GPs which will be the major user of that, and it is—we could probably—

Senator POLLEY: So you will be able to come back to us this afternoon with that figure?

Ms Jolly: Senator, the data that we have released on our bulk-billing we have by broad type of service.

Senator POLLEY: No, I am—

Ms Jolly: and that is to capture the range of services in general practice, not item by item.

Senator POLLEY: If you could take that on notice.

Mr Bowles: Senator, there are 5,700 items on the MBS.

Senator POLLEY: That is why I went for the most common one. If you can take that on notice, that would be fantastic. Thank you. Following on from Senator Di Natale, when we are talking about out-of-pocket expenses, Medicare statistics show that the average out-of-pocket cost for GP visits is almost up 20 per cent under this government. Is that concerning to you as the department? That the cost is—

Mr Bowles: We just read through the statistics that have actually—

Senator POLLEY: I think we disagree with the figures.

Mr Bowles: We hold the statistics. I can answer the question or—

Senator POLLEY: Great.

Mr Bowles: Or we can go down another pathway.

Senator POLLEY: You then are disputing the 20 per cent—that information that I have got?

Mr Bowles: I am not disputing anything. I am just saying that we just read out the statistics that over time, particularly since about 2011-12, they have been relatively stable. If you go back before 2011-12 to—I think Mr Stuart started about 2006-07—they were much higher increases in those early years. But it has stabilised over time, and they are consistent year on year. Now, equally, we need to understand that out-of-pockets are for the people who are not bulk-billed, so we are talking about the small proportion of people who are not bulk-billed.

Senator POLLEY: The Australian Bureau of Statistics says that one in 20 Australians are either delaying or avoiding going to their GP because of the cost. Will the freeze make that better or will it make it worse?

Mr Bowles: Again, I am not sure what you are referring to with the ABS but—

Senator POLLEY: They have obviously got some statistics—they have done a survey, and one in 20 people are either delaying going to their GP or not going at all.

Mr Stuart: I think all of the evidence that we have in front of us suggests that bulk-billing is rising; doctor supply per thousand population is increasing; doctor supply is increasing in rural areas as well as in metropolitan areas. In relative terms, to the past, you would not mount an argument that there is an access problem in general practice.

Senator POLLEY: I am not saying there is an access problem; I am saying people are avoiding or delaying going to the GP because they cannot afford to go. That is the point I am trying to make.

Mr Bowles: That is not what the numbers are actually telling us. Now, are some patients doing that? That is possible, I suppose. That is not what the data is actually telling us.

Senator POLLEY: As I tried to follow up with a question earlier this morning and was cut off halfway, the indexation freeze, you confirmed, started in July 2014.

Senator Nash: Senator, the freeze started under your Labor government.

Senator POLLEY: So the freeze from July 2014, which has started, was a whole-of-government decision—

Senator Nash: It started under your Labor government, under your minister Tanya Plibersek.

Senator POLLEY: It is going to be for six years. Is that correct, Mr Bowles?

Mr Bowles: The initial decision around freezes happened in 2013. A whole lot of these things come into effect at later dates, because they have a lag period. It started earlier and it is in place to the end of 2019-20, at this stage.

Mr Smith: The policy decision was taken for the 2013-14 budget.

Mr Bowles: That is correct.

Senator POLLEY: On the issue of the Royal Australian College of GPs or any others, have you had any discussion about the prospect of reindexing Medicare GP items only?

Mr Bowles: The minister has made it clear, as she talks to a lot of people about options around these sorts of issues all the time. She has been publicly saying that for the past, nearly, two years.

Senator POLLEY: Can you give us an outline, then, of what you know about the nature of those discussions and the outcomes? Have you been giving the minister any advice?

Mr Bowles: I do not know the nature of her personal discussions with a whole range of people she talks to. The minister has put it in the context of there is a budget repair issue. The government and the minister have been very clear about those sorts of issues. In the context of budget repair, if there were alternative ways of dealing with these things, she has said we can look at those. The current government policy goes out to 2019-20 and that is where we are, at this particular point.

Senator POLLEY: Have you been asked by the government and have you given any advice about alternatives?

Mr Bowles: Again, I am asked advice about anything and everything in the Health portfolio all of the time. Ultimately, it goes through a process and governments make decisions. Where we currently stand is with the freeze to 2019-20.

Senator POLLEY: What were the costs to reindex GP items only? Is the estimate by the Royal College of GPs, of $150 million a year, about right?

Mr Bowles: I think we would take that on notice.

Mr Stuart: Unfortunately, it is not right.

Senator POLLEY: Can you give us a figure, please?

Mr Stuart: The figure that has been quoted by the RACGP is a one-off one-year figure only, not a four-year figure.

Senator POLLEY: Can you give me the figure, to correct the record, please?

Mr Stuart: It is the reversal of the savings policy.

Mr Bowles: We will take it on notice, to be accurate. The figures that we have always talked about are the forward estimates periods. You cannot just say you will change it for one year, because if you change it for one year you change it for every year so it escalates year on year on year.

Senator POLLEY: Before we move on from this, are you aware of an article this morning, in the *Herald Sun*, that GP fees rise to $78 as doctors abandon bulk-billing? Have you seen that article—

Mr Bowles: I briefly saw it as I walked into here.

Senator POLLEY: Sorry, I have not finished asking my question. This article lists example after example of GPs walking away from bulk-billing, as I said, and are saying that the AMA is wrong when they say individual doctors are having to make the decision to abandon bulk-billing. Have you seen the article, is it incorrect and are you reasserting that doctors are not walking away from bulk-billing?

Mr Stuart: I did read the article. The data that we have been providing you with shows that bulk-billing is continuing to increase. In every most recent annual figure and quarterly figure, it is still continuing to increase.

Senator POLLEY: Yes, I recall that—

Mr Stuart: We cannot speak for every decision that every individual doctor might make. As the secretary said earlier, there is always a mix of doctors making differing decisions over a period of time. Nationwide, statistically, bulk-billing continues to rise.

Senator POLLEY: Do you disagree with the AMA?

Mr Stuart: We sometimes do.

Senator Nash: I might just, as we are talking about media articles, refer to one from *The Australian* in May 2013, when Labor froze the indexation, when they began this process—

Senator POLLEY: We are not disputing that.

Senator Nash: and their minister at the time, Tanya Plibersek, told *The Australian* that GPs could absorb the impact without having to opt out of bulk-billing. That was the position of the Labor government at the time when they brought in the freeze for the indexation.

Senator POLLEY: That was very helpful. If I can continue on—

Senator Nash: I would not want to misquote. I want to actually use the quote.

Senator POLLEY: Under the government's deal with the Diagnostic Imaging Association, the government has to re-index radiology rebates when it re-indexes GP rebates. How much will that cost?

Mr Stuart: Just give us a moment and we will find our place on that.

Senator POLLEY: Thank you.

Mr Stuart: To answer that question, we have not done a costing on that issue. It is actually out beyond the forward estimates period.

Senator POLLEY: So you have done no work on it thus far?

Mr Stuart: We have not done a formal costing on that.

Senator POLLEY: You have not done a forward costing. Will the government's deal with the Diagnostic Imaging Association make it easier or harder to re-index GP rebates? You must have done some work around that.

Mr Bowles: I do not see the correlation, necessarily. It is a cost to the bottom line, but that would be no real issue—whether you do one or the other, or both.

Senator POLLEY: I am seeking more information, if that is how it is.

Mr Bowles: Again, the current freeze goes to 2019-20, so anything past that is past the forward estimates and is not part of the current budget process.

Senator POLLEY: When could we expect, then, to have an indication of what the cost is going to be? You said you have not done all of that yet. Is that something you could take on notice and let us know about?

Mr Stuart: We cannot take it on notice because it is not information that currently exists. That would be something that, when the government makes a budgetary decision about that, the government would publish in its budget papers.

Senator POLLEY: Doesn't the July 2014 GP indexation show that this freeze is wholly a decision of the government?

Senator Nash: Well, the past Labor government started it, Senator.

Senator POLLEY: If the department can just answer.

Senator BILYK: No.

Senator Nash: It is a fact, Senator Bilyk, that you do not seem to want to hear.

Senator POLLEY: Mr Bowles, would you like to advise us?

Mr Bowles: Can you ask the question again?

Senator POLLEY: Does the July 2014 GP indexation show that this freeze is wholly a decision of this government?

Mr Bowles: No.

Senator POLLEY: You are saying it doesn't?

Mr Bowles: The actual decision, the first part—to freeze it—happened in early 2013. It took effect in July 2014, so it is—

Senator POLLEY: So 2014, 2015, 2016, 2017, 2018, 2019—

Senator SMITH: You might have been a Labor senator at the time, Senator Polley.

Senator POLLEY: is going to be under this government.

Mr Bowles: Clearly, this government has made decisions, but the question you asked me was: is it solely? And the answer is no, because the initial decision was made under the former government.

Senator POLLEY: We will deal, then, with Medicare. Statistics also show that the average out-of-pocket cost for a specialist visit is $75—up to 30 per cent—under this government. Will an ongoing freeze on the specialist rebates make that better or worse?

Mr Bowles: Again, if we go to the broad issue of out-of-pockets, they are growing at a roughly consistent level over time, and in quite a marginal sense. I do not know if there is anything specific on specialists, but I think that, in the broad sense that we have talked about before—

Senator POLLEY: With GPs, yes.

Mr Bowles: Yes, and they are roughly in the same sort of order. I do not have any better and further information at this point in time.

Senator POLLEY: There has obviously been some work done by the Bureau of Statistics once again, and they are saying that one in 12 people delays or avoids seeing a specialist because of the cost. Will this ongoing freeze on specialist rebates make that better or worse?

Mr Bowles: I do not think you can necessarily link the two issues. The Bureau of Statistics uses a whole lot of data, including socioeconomic data and welfare data and a whole range of things. Without going into the specifics of it and understanding it, I cannot answer your question any further.

Senator POLLEY: If there is anything you can add on notice, that would be very useful.

Mr Bowles: We can do that.

CHAIR: Just before I go to Senator McCarthy, there is a question of clarification.

Senator REYNOLDS: I have a question just on this point. My colleagues have quoted a number of varying statistics from varying sources—from newspaper articles to ABS data and a whole range of other things that do not seem to match up. I am just wondering: who keeps the authoritative statistics on bulk-billing?

Mr Bowles: We do a lot of the work to pull it together, but, ultimately, it is the Department of Human Services who owns the data, if you like. But we are the department who puts these sorts of things together and—

Senator REYNOLDS: Analyses it. So you could actually say that your department is the authoritative organisation that does these figures?

Mr Stuart: Certainly the Australian government figures are the authoritative figures. Over many years—20 to 25 years—we have been counting bulk-billing statistics on a consistent basis.

Senator REYNOLDS: Thank you.

Senator Nash: I might add to that as well, Senator. Mr Stuart is quite right. The way we look at the figures that the officials have been referring to this morning is exactly the same way they were looked at under the previous Labor government around how we approach this, and they are using the same standardised formula.

Senator REYNOLDS: In light of the fact that the department is the authoritative source of health data, particularly on bulk-billing, would it be possible to ask for a longitudinal look at bulk-billing rates nationally and then by state perhaps over the last 10 years? Just so we have a single source of information here so that we are not relying on newspaper articles, other commentators, colleges and whatever. Is that possible?

Mr Stuart: We will be able to table that a little bit later in the morning.

Senator REYNOLDS: If you could do it nationally and then by state also because obviously senators have interest in their own states.

Mr Stuart: Yes, we can do that.

Senator REYNOLDS: And perhaps you can also give us the out-of-pocket growth over the last 10 years as well. Is that possible to have a look at?

Mr Bowles: We will try and do that.

Senator REYNOLDS: Thank you. If you can do that today, that is fantastic. If not, you can do it later.

Mr Bowles: Yes, I will give it to you later.

Senator McCARTHY: Mr Bowles, I just wanted to touch on a couple of issues. One is Indigenous participation in the health sector. This may be more appropriate for Friday, but I just thought I would try while we are on this section of Medicare billing and looking at the statistics. I will go to the statistics first that Mr Stuart and Ms Jolly read out earlier about bulk-billing rates. You mentioned your statistics there for 2015-16. I just want to look at the Northern Territory. You said 87.4 per cent for the MBS bulk-billing rate for GP attendances.

Ms Jolly: That is correct.

Senator McCARTHY: I have in front of me an answer to a question on notice that was given to the committee this morning in response to Senator Gallagher's question on bulk-billing. I have the graph here. Do you have that in front of you?

Ms Jolly: I am not sure I do.

Senator McCARTHY: I would just like to check a couple of things in relation to the Northern Territory, if I may.

Ms Jolly: Sure. What number is that?

Senator McCARTHY: The reference number?

Ms Jolly: Yes.

Senator McCARTHY: It is SQ16-000071. Do you have that, Ms Jolly?

Ms Jolly: Yes, I do.

Senator McCARTHY: Could I take you to the final page of the question on notice response. If we can go across the graph to the average patient contribution and down to Lingiari and Solomon. There we have $40.54. Could you explain to me what that means in relation to the other states and territories.

Ms Jolly: Sure. Say I take Solomon—that line there. That says that you have a 87.1 per cent bulk-billing rate in Solomon. For those who are not bulk-billed, the average patient contribution would be $44.43.

Senator McCARTHY: When you say 'not bulk-billed', where would those patients be in relation to Solomon?

Ms Jolly: When a patient appears at a general practice, if the general practitioner takes the full cost of the service to be the rebate, it is considered to be bulk-billed. If the patient makes a contribution, that is what will show up in that table, and that is whatever the patient pays at that particular service.

Mr Bowles: It will be the average across the 12-point-whatever per cent of patients who are not bulk-billed.

Senator McCARTHY: You may want to take this question on notice, possibly for Friday. In terms of breaking that down, would you have the statistics for Aboriginal medical services and GPs who work in remote areas?

Ms Jolly: We do not have statistics by Aboriginal medical service. We collect statistics by the practitioners. So it would be difficult to correlate those two service types. Of course, Aboriginal medical services also have a 19(2) exemption, so they also have grant funding and would be providing a broader range of services than purely medical services. What we capture in the Medicare database will be your GP services that flow through Medicare. That is the information that we would have in this database.

Senator McCARTHY: How do you collate the information in terms of specifics around Indigenous health or Indigenous use of the Medicare rebate?

Ms Jolly: I would probably need to take some of that on notice. There is a technical calculation, where we estimate the use of Medicare for Aboriginal and Torres Strait Islander people. It is a methodology which is used. I am not the expert on that methodology, but I could certainly get you some information on how that works.

Senator McCARTHY: Who would know about that methodology?

Ms Jolly: We would just take that on notice. It would be someone that I would be able to get information from. Basically, it is the way in which we look at the MBS data and make some assessment of utilisation by Aboriginal and Torres Strait Islander people. But I would need to get some further advice to make sure I have given you the accurate information.

Senator McCARTHY: Thank you. I appreciate that. Just a heads up that that is where I will go on Friday. Thank you.

Senator POLLEY: Mr Secretary, earlier this morning you confirmed that the Turnbull government was still committed to abolishing the bulk-billing incentives for pathology. Has the department done any analysis on what impact that cut will have on patients and, if so, what does it show? Won't out-of-pocket costs in fact rise?

Ms Jolly: The department is working on the regulation of rental arrangements with Pathology Australia and with a range of providers. The understanding of that measure is that, when that comes forward to government, also the bulk-billing changes will come forward. Pathology Australia have indicated that those two measures together would mean that the bulk-billing changes would not have an impact on patients.

Senator POLLEY: So you are saying that, with the arrangements that are being put in place with the rental agreement, there will be no change at all to any patients with their out-of-pocket expenses; they will not rise?

Mr Stuart: The agreement with the industry is that there would be no need for changes to bulk-billing practices as a result of the removal of the bulk-billing incentive, as a result of the overall deal. We cannot, of course, rule out individual ups and downs in the ordinary course of commerce by individual providers.

Senator POLLEY: Can you give me a date for when the government is going to abolish the indexation? My understanding is that they have been pushed back from 1 July to 1 October. When will they finally come to fruition?

Mr Stuart: That is a matter for government.

Senator POLLEY: So you have given them no advice on that at all?

Mr Bowles: Not that would lead to an outcome, no.

Senator POLLEY: Can you tell me whether or not these delays have caused a cost to the government?

Mr Bowles: Not in the overall context, I don't think—other than a saving measure?

Mr Stuart: When saving measures are delayed, there is a cost to government.

Senator POLLEY: I would have thought it was obvious that when you to delay a cut there would be a cost. Is there any plan to make up that shortfall with further cuts to the health department?

Mr Bowles: That will be a matter for government, as that works its way through.

Senator POLLEY: Has the department given any alternative advice about savings, other than abolishing the plan to cut to pathology? In other words, you have not put up an alternative plan to the one that the government is implementing.

Mr Stuart: The government is very much working on delivering the existing deal with Pathology Australia.

Mr Bowles: That is the alternative, if you like.

Senator POLLEY: Who convened the roundtable with the pathology sector in April and why? Can you tell is who attended that roundtable from the government, the department and the pathology sector? Were there GPs or other professionals there?

Mr Stuart: I will ask Jaye Smith to paint this in. Broadly, the department asked BCG to convene and chair that meeting. The meeting itself was very ably chaired by a partner of BCG, Ant Roediger. It was his job to make sure that everyone around the table was very well heard—

Senator POLLEY: So who attended?

Mr Stuart: The kinds of people who were around the table included representatives of the AMA, the RACGP. They are obviously there with a view to doctors' interests. Also some individual providers of pathology services, Pathology Australia—and I am starting to run dry.

Mr Smith: The participants at the roundtable were: Australian Clinical Labs, Australian Independent Pathology Association, the Australian Medical Association, Catholic Health Australia, Pathology Australia, Primary Health Care, Public Pathology Australia, the Royal Australian College of General Practitioners, the Royal College of Pathologists of Australasia, Sonic Healthcare and the Department of Health.

Senator POLLEY: Can you tell me what the outcomes were from that roundtable meeting?

Mr Smith: Please bear with me for a moment, Senator.

Ms Jolly: The roundtable canvassed a range of issues around rental regulation and had a relatively broad ranging discussion about the issues that the sector faces. There are recorded minutes of that meeting, which have gone out to participants. That information then flowed into other discussions and provided advice. There were not outcomes in the sense that there were three things decided and that is now what is going forward; it was more a record of discussion of the range of positions and issues that the sector has around pathology rental regulations and the relationship with ACCs.

Senator POLLEY: Are you saying that there was no agreement about what the next step would be in this process? Were there no agreed positions taken at that meeting?

Mr Stuart: It was a consultation discussion and not a deciding discussion.

Senator POLLEY: Is it possible to get a copy of those minutes for the committee?

Mr Bowles: We could take that on notice.

Senator POLLEY: Did the department provide any advice to government on a possible deal with Pathology Australia? If so, when?

Mr Stuart: Right up until that day the election was called, the department was in discussion with the minister and the office about pathology issues. They were obviously a reasonably hot issue through that period. The day that the election was called, the department ceased advising the minister and the government about that issue, and subsequently the government struck a deal with Pathology Australia.

Senator POLLEY: So the department provided no information to the government after the election was called?

Mr Stuart: No, we do not advise governments about policy during that period.

Senator POLLEY: According to reports, the health minister's office emailed draft talking points on the deal to the department, and the department suggested deleting the suggestions that regulatory breakdown had 'allowed landlords to drive up rents'. Why was that communication carried out?

Mr Stuart: I do not have the particular piece in front of me. From time to time, what does happen during caretaker periods is that the department is the office is at liberty to ask factual questions of that department and from time to time they ask us to fact check particular things. But we do not provide advice on policy during that period.

Senator POLLEY: Was the department concerned that the policy was going to allow landlords to drive up rents? One would assume that must have been foremost in your mind if you communicated that to the minister's office.

Mr Stuart: I am sorry, I cannot confirm that particular communication. I do not have that in front of me. I am not aware of it.

Senator POLLEY: Can you take it on notice for us?

Mr Stuart: I do not have it so I cannot take it on notice.

Senator POLLEY: Are you saying there was no communication from the department?

Mr Bowles : We can take it on notice and check if there has been anything. We are just not aware of it. We can take on notice if there is a so-called piece of information.

Senator POLLEY: So would you be applicable back to us after the lunch break with that?

Mr Bowles : We can try but I am not sure will be able to do that.

Senator POLLEY: Does the department disagree that there is an issue with the pathology writs?

Mr Bowles : I think you are asking us for a view on a policy position that the government may not take. I do not think that is fair.

Senator POLLEY: Okay, so I will rephrase that. Were there any other suggestions made by the department to the government around this issue?

Mr Stuart: We have provided a range of options over a period of time. We would usually do that with reasoning and with pros and cons. The government's decision is always on the basis of advice from the department and other information and views that are made available to it.

Mr Bowles : Ultimately they are decisions of government.

Senator POLLEY: And you have already clarified that what you did was consistent with caretaker conventions?

Mr Stuart: Yes.

Senator POLLEY: Has the department had anything to the effect that the deal was strictly between the government and Sonic Healthcare? Would the department be concerned if bulk-billing incentives were abolished on the say so of one pathology giant?

Mr Bowles : Again, we cannot comment on what were private discussions between ministers and ministers' officers and somebody we do not know.

Senator POLLEY: You do not know?

Mr Stuart: The agreement is with the Pathology Australia.

Mr Bowles : We cannot comment on any of that stuff.

Senator POLLEY: Still with Pathology Australia, the government says that pathologists will maintain current bulk-billing rates. Is that a guarantee?

Mr Bowles : That is what it has said.

Senator POLLEY: So the government is guaranteeing that the bulk-billing—

Mr Bowles : No, that is what the Pathology Australia have said—they will not change the bulk-billing practices.

Senator POLLEY: I ask the minister: Is the government guaranteeing that bulk-billing in the pathology will not fall in, say, the September 2016 or December 2016 Medicare statistics?

Senator Nash: That is what the pathology industry have committed to. I am not going to call into question their integrity. We are taking it in good faith that that is exactly what they met and we expect they will do that. I am struggling a little bit with what the issue is.

Senator POLLEY: The issue is the government guaranteeing—

Senator Nash: Let me finish, Senator. We have an issue here which is a sensible measure. The funding that was outlaid only saw an increase in bulk-billing of 1.3 per cent, from 86.3 per cent to 87.6 per cent. The pathology industry has indicated it is going to keep the bulk-billing levels at its rates, which are quite high as I understand it anyway so I am struggling to see what the issue is.

Senator POLLEY: So then through your contribution, Minister, are you happy to guarantee on behalf of the government that there will not be any increase?

Senator Nash: You can try and put words in my mouth but it is not going to work.

Senator POLLEY: I am not; I am just asking the question.

Senator Nash: But it is not going to work. I am saying that the pathology industry has made a commitment and we fully expect them to uphold that commitment—unless you do not trust the pathology industry.

Senator POLLEY: The government's deal with Pathology Australia says that the government will legislate to address ambiguities and improve compliance regarding the charging of fair market value rents. Will it be legislation or regulation? When can we expect that legislation to come before the parliament?

Senator Nash: Not being the responsible minister, I will ask advice for that.

Ms Jolly: The department is currently consulting with a range of stakeholders on the exact model. That will need to be completed before we will advise on exactly the nature of the regulations and legislation that would come in front of the House.

Senator POLLEY: Will it be a package of regulations to abolish bulk-billing incentives, or will it be legislated or regulated separately?

Mr Bowles: What Ms Jolly just said—we are not there yet and that is a decision of government ultimately.

Senator POLLEY: What is the department's view as to what fair market value means? Is there any controversy over its meaning?

Mr Bowles: I think you are asking me to give a view on an alternate policy and I cannot do that.

Senator POLLEY: I am not asking you to give a view on an alternate policy. I am just asking the department's definition of fair market value in this context.

Mr Stuart: It is one of the things we are consulting about. You will be aware that there are differing views in the community about that.

Senator POLLEY: Absolutely, but you are the department, so I am really interested in your view.

Mr Stuart: We are very interested in other people's views so we can advise the minister about them and ultimately—

Senator POLLEY: So when can we expect—

Mr Bowles: these are decisions of government, not decisions of the department, irrespective of the advice that we provide.

Senator POLLEY: Do we have a time frame for when that consultation will be concluded and when we will see either the legislation or regulations? Is there a time frame to that?

Mr Stuart: We are currently working hard on it. I cannot give a specific time frame because discussion and consultation finishes when, essentially, the minister and the government make a decision and decide that they have had enough consultation.

Senator POLLEY: When the deal is done.

Mr Stuart: We are working quite hard on it and the government wants to honour the nature and the spirit of the agreement with Pathology Australia while consulting with all affected parties.

Senator POLLEY: The AMA, which represents pathologists as well as GPs, has called for the government to immediately drop its deal with Pathology Australia. What do you make of the AMA's concerns? I know that you will say it is government policy but the department must have a view in relation to the concerns the AMA are raising.

Mr Bowles: I think that is a little unfair. As Mr Stuart said, there are varying views. That is why we consult. That is why we want to talk to different players so we can actually formulate some advice to government. But ultimately, these are government decisions.

Senator POLLEY: Does the department have any evidence or data showing a link between the volume of pathology services and rents paid for co-located collection centres?

Ms Jolly: No, we do not.

Senator POLLEY: Has the Department of Health or the Department of Human Services taken any reinforcement action for alleged breach of the Health Insurance Act with respect to the rents for co-located collection centres?

Mr Bowles: We would have to take that on notice in relation to the Department of Health and you will have to ask the Department of Human Services.

Senator POLLEY: Please take it on notice. Are we likely to get that today?

Mr Bowles: I doubt it.

Senator POLLEY: Has the Department of Health—and we will ask the Department of Human Services—rejected any application from an approved pathology collection centre on the basis that the proposed rent breaches the prohibited practices provisions in the Health Insurance Act?

Mr Bowles: It would be best to ask DHS that one.

Senator POLLEY: Was there any specific consultation with the general practice groups about changing the current definition of market value for approved pathology collection centre rents prior to this policy being announced in the election?

Mr Stuart: Yes, and that was a purpose of the roundtable. There was a considerable amount of discussion leading into the roundtable and also subsequently.

Senator POLLEY: Great, thank you. Has the department taken any analysis of the impact of the proposed new definition—I guess I have asked that—of the market value? I think you have already covered off on that. Perhaps I can move on, rather than repeating myself. How long will medical practices be given to ensure that existing leases for co-located collection centres comply with the post-new market value definitions, if it is enacted?

Mr Stuart: There was a very good discussion of that issue, among others, at the roundtable. I think it was very clear to all participants, if there was going to be change, that there needs to be sensible change at a sensible pace to enable compliance. That will include the cessation of existing rental arrangements and the beginning of new ones, so there will be a phasing approach. We are consulting about that too, and so there is not a definitive answer, but I just want you to be aware that there has been a very sensible discussion about the need for a calm approach to be taken.

Senator POLLEY: The government's arrangement with Pathology Australia said there would be a moratorium on new approved pathology collection centres. What was the department's view on the feasibility of this proposal? Did you share the government's position?

Mr Bowles: I think you are asking us to comment on government policy now.

Mr Stuart: I can speak to what has actually been done, and I think that will go some way to addressing your issue. In the period following the commitment, the department looked hard at alternative ways of implementing the government's commitment and provided advice to the government accordingly. In the event, the minister has chosen to implement the moratorium through a mechanism which limits new approvals to a six-month period. That means that it is a way of implementing a moratorium which is consistent with regulatory requirements.

Senator POLLEY: Thank you for that; it is helpful. The government says its deal with Pathology Australia will maintain a diversity of providers in the sector. To your knowledge—can that be guaranteed?

Mr Bowles: I am not sure we can answer that, Senator.

Senator POLLEY: Minister, you do not want to commit a guarantee to that?

Senator Nash: I am certainly not going to speak for the minister, but I would understand her intent is absolutely to do as she says.

Senator POLLEY: Is the department aware that, after the government's deal, St John of God sold its pathology division to Clinical Labs, Australia's third-largest pathology provider. Does that not show that the government is not maintaining diversity in the sector?

Mr Bowles: I think how different groups choose to buy, sell and do whatever they do is a commercial decision, and not one for us.

Senator POLLEY: You are not concerned, then, that any further consolidation in the sector is a good thing, or what impact that may have on patients?

Mr Bowles: I think we will always have a monitoring eye on consolidation in the market. These things have a habit of going up and down. We will continue to monitor it. I would not want to go much past that, at this point.

Senator POLLEY: My final question, then, would be: why did the government drop the moratorium in August?

Mr Stuart: I think I just went through a little while ago the way that the government has gone about implementing an effective moratorium in this area.

Senator POLLEY: So things did not change in August?

Mr Stuart: The method chosen to implement a moratorium was one which was capable of being implemented through existing regulation. That was an attractive way of giving effect to the government's policy.

Senator SMITH: Just briefly, on the same issue, from the perspective of the consumer will there be a change to a patient's Medicare rebate as a result of the measure?

Ms Jolly: No.

Senator SMITH: I read that Pathology Australia has said, as a result of the discussions and negotiations, that:

This in turn, will allow the sector to maintain current billing practices, in the best interests of patients.

Pathology Australia has not stepped back from that statement?

Mr Bowles: No.

Senator REYNOLDS: Secretary, I would like to come back for some clarification on the discussion of the Medicare pause or freeze on indexation. Obviously, I was not here when all this happened. Could you go back and give us a concise history of the issue, when it started and how it progressed through to this point?

Mr Bowles: It might be best if I get Mr Stuart to talk about that, but I think the initial freeze started in early 2013. Can you talk about that?

Mr Stuart: I will ask Maria to find that. We have set all this out very carefully. I found it in the *Hansard* from May. In fact, there have been indexation freezes in respect of pathology and diagnostic imaging which go back much longer. But if we are starting with the recent history then I will ask Maria to dig in from 2013.

Ms Jolly: Pathology indexation ceased in 1998, and diagnostic imaging was last indexed in 2004. In the budget of 2013-14 there was a decision to change the indexation arrangements for a general practice. In essence, this moved the indexation from November to July of the following year, which was an effective pause. There was then, for general practice, an indexation in 2014. At the end of 2014 there was a subsequent decision to pause indexation

for general practice services, and then in the 2016-17 budget a two-year pause was announced.

Senator REYNOLDS: So it started in the 2013-14 budget, and that would have been under Minister Plibersek at the time. At the time of that original decision in the 2013-14 budget, the health minister noted that doctors earn enough money to bear the federal government's freeze on MBS rebates. That was Minister Plibersek, I think. She noted that the average doctor gets $350,000 a year in Medicare billings alone. Do you have those figures for GPs? Was the minister right back then that that is what they get from Medicare every year, on average?

Ms Jolly: You are looking for total benefits paid over a number of years?

Senator REYNOLDS: Just to be clear, what I am looking for is the figures in 2013 when this policy was introduced. The minister at the time made the assertion that GPs could afford this measure because the average doctor gets $350,000 a year in Medicare billings. I am just wondering if you have figures for that year, perhaps before and afterwards, just to give us an idea of—

Mr Stuart: I think, unfortunately, although we are looking for data, we would have to take that one on notice. We have information that is a little bit broader than just doctors with us today, but we can probably come back to you later in the day on that for that specific time.

Senator REYNOLDS: Again, not to go through and recrunch some numbers, but do you have some figures that would contextualise this in terms of not only the minister's statement at the time, but also what the average doctor now is getting back from Medicare? If that is what they were getting from Medicare at the time, and it was probably 75 per cent bulk-billing rates, then you would think that the average salaries for GPs would be somewhere around the $400,000-plus mark. If you could come back later in the day, it just might put some context around the numbers.

Mr Stuart: The minister of the day said doctors, so I assume that that probably includes specialists as well as GPs. We first of all have to establish that we are looking at the data on a constant basis and then update it. We will see what we can do before the end of the day.

Senator REYNOLDS: I know you keep longitudinal data based on the same datasets, so if you are able to break it down by GPs, by specialisation, I think that would be very instructive for the committee.

Senator DI NATALE: I might just ask a couple of things about the pathology arrangement. As far as I understand it, you have a bunch of general practices who are charging way above market rates to allow pathology services to use their rooms, and this arrangement caps the rent that is payable to GP clinics. Is that how it works?

Mr Stuart: At the moment there are a range of GP practices that have space set aside for pathology collection centres. There is a variety of rents for those spaces, but some of them are very well above others, and much more than any other use of that space would command.

Senator DI NATALE: So it is well above market. What does the deal capped at?

Mr Stuart: We do not have a definition of that at the moment. We are in discussion about what that definition would be. There is currently a definition of market rent in the regulations, which has become a matter of dispute.

Senator DI NATALE: Between? Who are the disputing parties?

Mr Stuart: Between differing players, but, broadly, pathology interests and GP interests. There are two ways of thinking about the market. One way is that it is a market for pathology collection centres outside GP clinics. A different view of that market is that it is a market for what it is appropriate to pay for a clinical space of that kind if it had another use. They are the kinds of issues we are consulting about at the moment.

Senator DI NATALE: Given that a lot of general practice practices are using the rent that they are getting from pathology providers to subsidise their business, and given the impact of the freeze is still—one will assume—yet to be felt, if we take those figures you have given at face value, have you done any work to look at what impact this will have on bulk-billing rates?

Mr Stuart: I think we have just been talking about that a little bit.

Senator DI NATALE: Sorry, I missed some of that conversation.

Mr Stuart: Essentially, the nature of the deal between the government and Pathology Australia is to work to bring rents down to a more reasonable level and, at the same time or in some relationship to that, to continue with the government's proposal to remove the bulk-billing incentive.

Senator DI NATALE: I am not talking for pathology services; I am talking about GP services.

Mr Stuart: Sorry.

Senator DI NATALE: You have put yourself in the position of a general practice, right? You are getting significant rent from a pathology provider. Suddenly that is gone. You have the freeze as well. Have you done any work to say, 'Well, hang on, if we do these two things together, what's it going to mean for general practice and bulk-billing?'

Mr Stuart: Not specifically, no.

Senator DI NATALE: Do you expect it will have an impact?

Mr Stuart: What we are seeing in all of the data we have been talking about today is that it is doctor supply and doctor competition that is driving up bulk-billing rates.

Senator DI NATALE: Yes, but that is without this intervention.

Mr Stuart: Yes.

Senator DI NATALE: There are arguments, I understand, in all directions around whether it is appropriate or not that this model should exist, but it does exist, and it is helping to pay the bills for a lot of general practices. Suddenly that is gone. What does that mean for bulk-billing rates?

Mr Stuart: We do not have the basis for any specific modelling on that issue.

Senator DI NATALE: Do you have concerns that it might lead to an impact on bulk-billing rates?

Mr Bowles: I do not think we could answer that at this particular point. I think it will depend on the business model of the doctor—corporates will be different to individuals—and things like how many individuals versus corporates own things. We would not have that at this particular point.

Senator DI NATALE: You have not done a regulation impact statement?

Ms Jolly: Not at this point.

Senator DI NATALE: Is there any reason for not doing that?

Ms Jolly: We are still consulting on the model, so we are not at a point where we would take that step.

Senator DI NATALE: Sorry, you are consulting on the model? What does that mean?

Ms Jolly: We are consulting with a variety of players about what and how the parameters that you have talked about—market value and other things—might be defined, what sort of transition arrangements might be put in place, and concerns that peak bodies and others are sharing with us about the impacts. That will then come together in some advice around a model or models.

Senator DI NATALE: You mentioned earlier that there are different models of practice—corporate practices solo GPs and group practices. Can you outline who you think will be impacted most by this?

Ms Jolly: I do not think we have the data to really give a detailed answer to that question. I think it will obviously depend on the model and the rental arrangements that the particular practice has, and the final regulation model that is settled on. I cannot answer.

Senator DI NATALE: Is that vertical integration more an issue within large corporate practices.

Ms Jolly: It is hard to say.

Mr Stuart: There is a wide variety of arrangements. There are GPs who own the space, there are GPs who rent the space and then sublet, there are public providers that have very cheap rent as part of other kinds of state facilities, and there are providers that are both a pathology provider and a GP provider and manage the relationship on that basis. It is quite a complex picture.

Senator DI NATALE: When do you expect the changes to be bedded down? Do you have a time line?

Mr Stuart: We do not at this point have a final time line.

Senator DI NATALE: How do you get the agreement of Pathology Australia with this vague promise of, 'We're going to crack down on GP rents'? How does that happen?

Mr Stuart: The government made a specific agreement with Pathology Australia during the caretaker period. It was a government negotiation, not a departmental negotiation.

Senator DI NATALE: And so at this stage it still may be that this deal may not come to pass?

Mr Stuart: No, there is a clear agreement, and it was clearly documented and stated by the government at the time in a public statement. What we are doing is assisting the government to work through the specifics of implementation.

Senator DI NATALE: A sticking point at the moment is what the definition of market rent is.

Mr Stuart: That is one of the issues.

Senator DI NATALE: What are the other sticking points?

Mr Stuart: I would not call them sticking points. They are issues that need careful definition.

Senator DI NATALE: What are the others? Or is that the primary one? You have mentioned there is a range of issues.

Ms Jolly: Market value and how you would define it is certainly one. Transition arrangements is another.

Senator DI NATALE: What does that mean?

Ms Jolly: If you are to put in place legislation, what sort of lead time you would need to put in place to deal with existing leases or existing arrangements and how that would work. There are then issues about how it relates to the existing prohibited practices arrangements and how those two things work together. But the discussion is largely around the definitions that you have indicated.

Senator DI NATALE: I have one more question going back to that issue of the table that we were discussing. Just so we are clear, it is the Medicare statistics table 1.5a. I think that is what you were looking at as well. Is that correct?

Ms Jolly: I am not sure. What did you say? Was it 1a?

Senator DI NATALE: We had this discussion about out-of-pocket costs, and I have the data from the Medicare statistics—table 1.5a—which has the MBS average patient contribution per service for out-of-hospital and patient billed services and then broad type of service: non-referred attendances—GP/VR GP. The information you gave me, Mr Stuart, was based on the GP services. Is that right?

Mr Stuart: Yes.

Senator DI NATALE: You gave me percentages over that period of time.

Mr Stuart: That is correct.

Senator DI NATALE: I suppose what I am looking at is the increase. If you look at, for example, the increase in out-of-pocket costs for the previous financial year, it was $1.10, but in this financial year it has almost doubled. It is over $2 on average. Is that correct? I just want to make sure I am reading this properly.

Ms Jolly: Senator, we are going to need a copy of that table.

Mr Bowles: Would you be able to table what you are looking at, and we can try to see if it actually matches anything of ours?

Senator DI NATALE: Yes. I have a bit of scribble on it, but I am happy to table that.

Mr Bowles: If we can have a look at that and see if we can make sense about where it has come from, we can come back to you on that.

Senator DI NATALE: Yes. It is the Department of Health Medicare statistics. It is table 1.5a. Until we get that, I am quite happy to sit until we can come back to it.

Senator POLLEY: The government's deal with the Australian Diagnostic Imaging Association does not say that radiologists will maintain current bulkbilling rates. Is there any guarantee in that deal that they will?

Mr Bowles: I will make a broad point before anyone says anything. We are not into guarantees. I think it is quite unfair to ask officials at the table to guarantee a whole lot of things. Governments make policies, and in some cases they have arrangements with other parties—in this case, Australian Diagnostic Imaging Association; in the previous conversation, pathology—and they commit to do things. We take that at face value, and we will monitor bulkbilling rates and out-of-pocket rates, and we will report back on all of those things. I just think it is unfair to ask: can we guarantee?

Senator POLLEY: I take that point, and I think I can recite what Senator Nash will say as well. The government's deal with the Australian Diagnostic Imaging Association says:

The Coalition will ensure that diagnostic imaging indexation resumes when the current GP rebate indexation freeze concludes

Do you have any reason to think that the government will end the GP freeze sooner than is scheduled? I think you have said: no, they will not. You do not expect them to.

Mr Bowles: That is a government decision. The current position is that it is out to 2019-20. Now, if the government chooses to change that tomorrow, that is fine. If they change it in a year, that is fine. But where we currently sit it is 2019-20.

Senator POLLEY: Will there be any cost in re-indexing the diagnostic imaging items now included in the budget from 2020?

Mr Stuart: Yes, there will be a cost. However, as we said before, that cost is out beyond the forward estimates and we have not yet estimated that cost or agreed it with the Department of Finance.

Senator POLLEY: You have no indication at all what it would be in the four years or 10 years?

Mr Stuart: We do not have that.

Senator POLLEY: Does the government's deal with the ADIA make it more or less likely that the government will re-index GP items?

Mr Bowles: Again, that is not something I can answer.

Senator POLLEY: The government's arrangement with ADIA says that the government will reinvest as much as $50 million per year of its cuts to radiology, subject to the outcomes of evaluation. Why is that $50 million not included in the government's election costings?

Mr Bowles: I am not sure of the timing of all of that. I would have to take that on notice.

Senator POLLEY: If it is not in the budget, could we assume then that it does not exist?

Mr Stuart: No. There was a clear policy commitment by the government, but it was a figure that was 'up to'. The government's commitment states 'up to' $50 million, and the work that is being done will help the government to establish what is the appropriate amount and what is the appropriate way to distribute it.

Senator POLLEY: Did the department provide any advice to the government on a possible deal with the ADIA?

Mr Bowles: I think we will go back to what we said about the other one. Up until caretaker we provided advice, post caretaker we backed out, and we came back in subsequent to the election and we deliver whatever advice to the government of the day.

Senator POLLEY: Is the department aware of any of personal relationships between the Diagnostic Imaging Association and the minister's staff at the time of the deal?

Mr Bowles: It is not a question I can answer.

Senator POLLEY: You are not aware, then, or—

Mr Bowles: I am not aware of any, but it is not a question that I can truly answer, whether they are there or not. It is the minister's office.

Senator POLLEY: Perhaps it might be appropriate for Senator Nash. Are you aware of the personal relationship with minister's staff and the ADIA, and were there any steps taken to manage that conflict of interest?

Senator Nash: I am not aware of any of that.

Senator POLLEY: Are you willing to take that on notice?

Senator Nash: I can do that for you.

Senator POLLEY: When will the government deliver on its commitment for a PET scanner for the Alan Walker Cancer Care Centre in Darwin?

Mr Smith: That is a matter for the department of infrastructure.

Senator POLLEY: It does not come out of Health?

Mr Bowles: The department of infrastructure would fund that as per the election commitment.

Senator POLLEY: During the campaign, the minister committed to full MRI licences for Frankston Hospital and Maroondah Hospital, which are both in marginal electorates in Victoria. Did the government commit to any other diagnostic imaging licences or equipment?

Mr Bowles: Not that we are aware of.

Senator POLLEY: Did the department provide any advice to the government on those commitments?

Mr Bowles: No, definitely not during caretaker. We might have provided advice earlier, but I do not know anything specific on those issues.

Senator POLLEY: So if there was no advice, then you had no view on whether Tweed Hospital in New South Wales should have been included?

Mr Bowles: No, not at this point.

Senator DI NATALE: You have the table now. Was this the same table you were quoting from earlier, Mr Stuart?

Mr Stuart: The table that I was quoting from earlier was produced for me specifically by my staff and it was in constant prices. That is a slightly different basis of information from that which is published in this table.

Senator DI NATALE: Let us look at the information published in this table. What we see with the out-of-pocket costs for GP services is that if we go to 2011-12, the increase is about $1.60 to 2012-13, in 2013-14 it is very similar, it is $1.10 for 2014-15 but then there is a big jump from $1.10 to over $2 in terms of average out-of-pocket costs from the previous year to this year.

Mr Bowles: If those numbers are correct, that is correct.

Senator DI NATALE: They are your numbers.

Mr Bowles: Yes, exactly, but let us get it in context. We are talking about the just less than 15 per cent of people in that context.

Senator DI NATALE: I understand the context—we are talking about average out-of-pocket costs.

Mr Bowles: Yes, average out-of-pocket on those who are not bulk-billed.

Senator DI NATALE: That is right. If the bulk-billing numbers are to be taken as accurate—and we do not know the proportions of people who are bulk-billed, but we know services, so let us take the data on services—then, given there has been a significant increase in out-of-pocket costs over the last financial year for those people who are charged out-of-pocket costs, and I agree it is a minority, it is fair to assume that the cost of the freeze—this is a hypothesis but I think it is a reasonable one—is being borne by those individuals who are being charged out-of-pocket costs.

Mr Bowles: I think that might be a bit of a stretch.

Senator DI NATALE: How else do you explain it? We are talking about a significant increase over the last financial years.

Mr Bowles: Let's get it in context. We are talking about $2, and I do not consider that to be significant for the marginally less than 15 per cent who are charged.

Senator DI NATALE: If you have a chronic disease and you are visiting the GP every week and you live in a place where there is no bulk-billing, $2 actually adds up.

Mr Bowles: And we have already heard that those who are more likely to see the doctor more often are more likely bulk-billed, and they are not in this category that we are talking about.

Senator DI NATALE: And we also know that people who live in rural areas are less likely to be bulk-billed.

Mr Bowles: That is not what the data is actually showing.

Senator DI NATALE: That is absolutely what the data shows. Are you suggesting that, if you live in a rural area, you are not less likely to be bulk-billed?

Mr Stuart: On average, across rural area, the bulk-billing rate for GPs is above 80 per cent.

Senator DI NATALE: Compared to cities; compared to urban areas?

Mr Stuart: Yes. It is slightly lower.

Mr Bowles: It is still above 80 per cent, Senator.

Senator DI NATALE: That statement was that you are more likely to be bulk-billed. You are not.

Mr Stuart: There is a reason that we cannot draw hard and fast causal links in this data. I will give you an example. During the years 2004-06 the government significantly increased its investment in general practice by implementing the bulk-billing incentive and by moving from 85 per cent to 100 per cent of the scheduled fee. During those years the bulk-billing rate started to go quite sharply and has continued to ever since an the out-of-pocket costs also

went up quite sharply, although the rebate was being increased significantly and rapidly during that period.

Senator DI NATALE: I understand that, but them most significant intervention that we have seen over the recent two financial years has been the Medicare freeze. It has been the only major structural change. In the most recent financial year we have seen a significant increase in out-of-pocket costs for those people who are being charged out-of-pocket costs.

Mr Stuart: I hesitate to draw any causal link.

Senator DI NATALE: You might hesitate to draw a causal link. It is partly our job to try to untangle that—which is why we had conflicting information. The information here is pointing very clearly to the fact that, in the last financial year, we saw a significant increase in out-of-pocket costs for those people who are not being bulk-billed.

Mr Bowles: I just question the wisdom of continually saying 'significant' when we are talking about a roughly $2 increase in the group of patients who are not bulk-billed, which is 85.1 per cent. I accept your premise that it has gone up, but—

Senator DI NATALE: They are not numbers; it is not my premise. They are your numbers.

Mr Bowles: You are drawing conclusions from the numbers and using words like 'significant'—and that is my point. We are talking about that smaller proportion that are not bulk-billed, and we have had a lot of commentary today around rural, regional, remote, metro and outer-metro all being above the 80 per cent. We have had a number of conversations around these sorts of things.

Senator DI NATALE: You gave examples of your own personal experience, Mr Bowles. There are many people who live in regional areas where you just cannot get a bulk-billed service—you cannot.

Mr Bowles: If you look at the statistics. If you are over 80 per cent, people are being bulk-billed.

Senator DI NATALE: That is not what you presented earlier—80 per cent of services. It may be much less in terms of the percentage of people who are being bulk-billed. So let's be accurate about this.

Mr Bowles: Again, we go to services, because that is the usage issue—

Senator DI NATALE: You said 80 per cent of people are being bulk-billed.

Mr Bowles: I am sorry; I meant services.

Senator DI NATALE: It is encouraging that bulk-billing rates in terms of services remain high. That is a good thing. But we also need to consider what is happening to that 20 per cent cohort who are not being bulk-billed. Many of these live in regional areas, and if you live in a regional area you are less likely to receive a bulk-billed service. If your senior GP—

Senator REYNOLDS: It would be helpful if you could get that statistic.

Senator DI NATALE: He just read it out.

Senator REYNOLDS: I heard Mr Stuart say the opposite.

Senator DI NATALE: Well, you obviously were not listening, Senator. Could you read out the difference between bulk-billing rates in regional areas versus urban areas?

Mr Stuart: Total non-referred attendances—so we are talking about GPs—major cities, 85.8; inner regional, 82.7; outer regional, 83.9; remote, 83.4; and very remote, 87.7. Total average, 85.1.

Senator DI NATALE: Again, if you live in three of those four regional categories, you are less likely to be bulk-billed than if you live in a city.

Mr Bowles: But we vary from 82.7 to 87.

Senator DI NATALE: If we are talking raw numbers for 'very remote' versus the other three categories, the other three categories are significantly higher in terms of representation.

Senator REYNOLDS: But the 'very remote' area was 87 per cent, which is the highest rate of bulk-billing. Is that correct?

Senator DI NATALE: Do you have the total number of people who classify as 'very remote' compared to the other three regional categories?

Mr Stuart: 'Very remote' is a relatively small group of people.

Senator DI NATALE: Tiny. Exactly.

Mr Bowles: But in the other three categories, we are still talking an average of above 83 per cent.

Senator DI NATALE: Yes, but still lower than in an urban area. I do not even know why we are arguing that, because that is widely accepted.

Mr Bowles: Marginally lower.

Senator DI NATALE: Yes; a couple of per cent, but a couple of per cent is still significant.

Mr Bowles: But in absolute numbers, there are more people in the metro regions than in those other three categories.

Senator DI NATALE: Sure. The point is you use your own experience. Let me put to you the experience of many people that live in regional areas. In many towns you simply cannot find a bulk-billing GP. I do not know that we need to actually have a debate around that. Senator Nash, I am sure you would accept that. If the freeze is leading to an increase in out-of-pocket costs for those people who are not being bulk-billed, it is reasonable to assume that the cost of the freeze is being borne by those people who might live in regional areas, who cannot get access to a bulk-billing general practice.

Mr Bowles: I do not necessarily accept every part of what you said to draw the conclusions you have. There are variations across those categories in the order of two per cent—you are right. In an absolute numbers sense, there are more in the metropolitan area. I accept that there will be difficulties in some places to get access to bulk-billing. But if you look across these areas that, on average, are above 83 per cent, there are still a lot of services being offered in the context of that. If you have multiple visits, we have heard that you are more likely to get bulk-billed irrespective of where you are. We are only talking about that 83 to 85 issue in this particular context. I accept there will be some variation in all of these places, but I do not think you can draw that conclusion all the way back to the freeze.

Senator DI NATALE: I think it is the most significant intervention, and we have seen, correspondingly, an increase in out-of-pocket costs for people who are not being bulk-billed.

Mr Bowles: But out-of-pocket costs have been increasing year-on-year. There has been a marginal change.

Senator DI NATALE: This is a doubling from the previous year.

Mr Bowles: A doubling on $1 to $2.

Senator DI NATALE: One dollar to $2—if you are seeing the GP every week—makes a significant difference. It can add up to hundreds of dollars.

Mr Stuart: There is variability in the data. There are differing percentage increases and dollar increases over a period of time. The previous year was a comparatively low figure. The year before that, the increase in out-of-pocket costs was a little higher. I think it is very difficult to draw a specific causal inference.

Senator POLLEY: There is a significant difference between a dollar extra for us sitting around in this room and for those people who are on much-lower wages.

Mr Bowles: Absolutely. And it is highly likely that the people who are paying the dollar are people like us as well. I think there is more chance of that than not.

CHAIR: Before we proceed any further, I just ask that we continue with questions and answers rather than a debate.

Senator DI NATALE: I wanted to bring this table up because, obviously, we had conflicting data—and I have done that. I am pleased to see that the information we have got is accurate. The cause of that is obviously something that we will need to explore. Should there be a significant increase in out-of-pocket costs of that magnitude or greater in the next financial year, I think we do need to accept that that is the most likely cause and, indeed, I would suggest that it is probably the most significant factor that has contributed to that outcome. I will leave it there.

Senator REYNOLDS: I want to come back to a couple of issues in relation to Medicare expenditure, and I applaud my Labor and Greens colleagues for what I could only call their statistical gymnastics in trying to demonstrate or find some aspect of unequivocally good news actually being bad news. I think you would get a gold medal for attempt but zero for execution.

Senator POLLEY: Try talking to people who cannot get in to see a GP.

Senator DI NATALE: If you are paying for general practice services that cannot get bulk-billed, that is not—

Senator REYNOLDS: Clearly the evidence this morning has been that bulk-billing news is unequivocally good and it is going up.

Senator DI NATALE: No, it is not. That is simply inaccurate.

Senator REYNOLDS: Chair, if I wanted a debate with my colleague Senator Di Natale I think we could have that out of this session. I would actually rather hear from the secretary if I could.

CHAIR: Me too. We will proceed to a question, I think.

Senator REYNOLDS: So, thank you for going through the information on bulk-billing this morning. Senator Di Natale might choose to see—I am not sure what cloud hangs over

those great numbers. However, I would like to ask you whether you could go through what the Medicare spending was for last financial year—2015-16—and what it is this year.

Ms Jolly: In program 4.1, medical benefits, the total for 2015-16 is $21,208,995 million.

Senator REYNOLDS: And this financial year?

Ms Jolly: The 2016-17 budget, $21,969,725 million.

Senator REYNOLDS: So, this year is an increase on last year.

Ms Jolly: That is correct.

Senator REYNOLDS: Can you tell me what it is over the forward estimates?

Ms Jolly: The forward estimates for 2017-18: $22,673,612 million.

Senator REYNOLDS: That is very precise. Thank you.

Ms Jolly: For 2018-19, $23,680,664 million, and for 2019-23, $25,126,850 million. Just to be clear, that is program 4.1, medical benefits.

Mr Bowles: I think we gave you some figures earlier on in a broad category, which were whole-of-government health costs. If there is any difference, that is the difference.

Senator REYNOLDS: Given my colleagues' love of facts and statistics, I thought it would be quite helpful to clarify it a bit further. What is the increase from last year through the forward estimates in percentage terms each year? Do you have those numbers there?

Ms Jolly: It is in the order of four per cent, but I would need to work it out.

Mr Bowles: My rough memory of this is that it goes from about four to 4½ per cent, I think—year on year, that is.

Senator REYNOLDS: Year-on-year increase—which is above the inflation rate at the moment, clearly.

Mr Bowles: Yes.

Senator REYNOLDS: So, is there any doubt in your mind, as the secretary of this department, that we are actually increasing year-on-year expenditure on medical benefits?

Mr Bowles: We are increasing, and, as I said, the year-on-year increase in the MBS is roughly around four to 4½ per cent.

Senator REYNOLDS: So, this year's expenditure: has there ever been a higher expenditure on Medicare than we currently have? Has any other government ever spent more than this government is currently spending on Medicare?

Mr Bowles: I will answer that by saying that we have increased expenditure on the medical benefits to the highest level, and it will continue to go higher, as Ms Jolly just read out, over the next couple of years.

Senator REYNOLDS: In layman's terms, no other government has ever spent more on Medicare than this government currently is?

Mr Bowles: Let me answer that by saying—

Senator POLLEY: People are paying more for their GP than ever before. They are paying far more to see a doctor.

Mr Bowles: Rather than putting it in the government context, I, as a humble public servant, put it in the context that in the spend on the MBS we are finding, year on year, that

more and more money is being spent on the MBS—as Ms Jolly said, growing from currently around $21 billion to over $25 billion, which roughly equates to around four to 4½ per cent year-on-year growth over the forward estimates.

Senator REYNOLDS: Just to put to bed some of these conspiracy theories and allegations and things that we hear in the media: you are not aware of any government intent to cut the funding that you have just outlined for the MBS, for Medicare?

Mr Bowles: No.

Senator REYNOLDS: And perhaps, on notice, you could provide those figures in writing, along with the percentages, and go back 10 years as well—the past 10 years, including the forward estimates. I think that would help the committee and possibly those out in the public as well.

Mr Bowles: We will take that on notice.

Senator POLLEY: I would like to put a question on notice as well. Following on from what was just asked for on the expenditure, could you give the figures for the same decade and the forward estimates of the increase in out-of-pocket expense and how that has increased over the years?

Mr Bowles: We have taken that on notice already, I think, but yes.

Senator POLLEY: Yes—just so it correlates with her time frame. That would be great.

Mr Bowles: They are two different issues, but—

Senator POLLEY: But the same time frames. We can agree on that.

Mr Bowles: I am sure it will get put together somewhere and we will come up with one and one is three. But anyhow.

Senator POLLEY: It is all useful.

Senator REYNOLDS: Thank you very much for agreeing to provide those figures, because I think they will conclusively show that any conspiracy theory that this government is going to be reducing expenditure on Medicare is as dead as a dodo, because clearly the evidence is not there that it exists.

Senator POLLEY: Is that a question, or—

Senator REYNOLDS: No, I am just thanking the secretary.

Senator POLLEY: So, moving on to pathology and diagnostic imaging, Secretary, can you tell the committee what the pathology sector itself has said about the impact that the commitment will have on bulk-billing practices? Have you had any feedback from the pathology industry at all?

Mr Bowles: Broadly they have committed that there will be no impact on that, but I will get my colleagues to—

Senator REYNOLDS: So, the pathology industry itself says there will be no impact.

Mr Bowles: It goes to a point I made earlier that I am not guaranteeing anything but we do have arrangements with the pathology and DI sectors and they have committed to certain things and we would expect them to deliver on those.

Senator POLLEY: We already had that in evidence.

Senator REYNOLDS: I have a different set of questions. I just want to set up my questions. Can you remind us of when the bulk-billing incentive was introduced for pathology?

Mr Bowles: I will have to get my colleagues to answer that.

Senator REYNOLDS: Perhaps when it was introduced and how much it was.

Mr Bowles: So, this is bulk-billing incentives on pathology. My recollection would be about a decade or so ago, but let's see if we can get the right answer.

Mr Smith: The bulk-billing incentive was introduced in 2009-10.

Senator REYNOLDS: That was pretty close, Secretary. And what was the cost?

Mr Smith: It was at a cost of $500 million over the following five-year period.

Senator REYNOLDS: So, for $500 million worth of taxpayer funding in this area, what difference did it make? Do you have some statistics on the difference it made over that time?

Mr Bowles: To bulk-billing rates?

Mr Smith: Yes, bulk-billing rates increased by one per cent in that five-year period.

Senator REYNOLDS: Very interesting. How much was it worth to pathology services? By service, what did it equate to?

Ms Jolly: We do not have that information, sorry.

Senator REYNOLDS: I understand that it was somewhere in the order of $1 to $2.

Mr Smith: Yes. It was a couple of dollars. I will get you the exact figures in a minute, if that is okay.

Senator REYNOLDS: So, it was a scheme that cost $500 million, and it was worth roughly $1 to $2 per pathology service, and it changed bulk-billing rates over that time by one per cent.

Mr Smith: Yes.

Senator REYNOLDS: That is hardly a resounding success for the taxpayer. Was it paid to the provider, or did this go to the patient?

Mr Smith: It is a payment to the provider.

Senator REYNOLDS: So it did not go to the patient. Was there any change to the patient's Medicare rebate as a result of this measure?

Mr Smith: No.

Senator REYNOLDS: It made no impact on the Medicare rebate for the patient?

Mr Smith: No.

Senator REYNOLDS: Thank you. That is very interesting. I have a similar series of questions for diagnostic imaging. Have you had any feedback from the diagnostic imaging sector about impacts the commitment will have on their billing practices?

Mr Bowles: It is largely the same as I said for pathology. We expect that if we enter into arrangements with players that they deliver, and they said it will make little difference.

Senator REYNOLDS: So they say it will make little difference. When this bulk-billing incentive was introduced, was it introduced at the same time as the pathology incentive?

Mr Smith: I am just checking that. I will need to confirm, but I understand it was introduced at the same time.

Senator REYNOLDS: So around the 2009-10 financial year, around about the same time. How much is being spent on bulk-billing incentives under this program for diagnostics since that time?

Mr Smith: I do not have in front of me how much was spent since introduction of the measure, but I can get that.

Senator REYNOLDS: Could you come back to me with whether it is about the same as pathology or if it is a lot more, and how much of the taxpayers' money has gone into that?

Mr Smith: Yes.

Senator REYNOLDS: What was the increase in bulk-billing rates for this figure we are going to find out? What were the results of that?

Mr Smith: I will bring you the exact figures. It was a marginal increase in the growth rate in the bulk-billing rates for diagnostic—

Senator REYNOLDS: A marginal increase in growth rate, so it could be around the one per cent like it was for the pathology increase? Anyway, I will wait for you to come back with that.

Mr Bowles: It is a slightly different context in this one.

Senator REYNOLDS: Okay, I will wait for that.

Mr Stuart: It is a different kind of answer. Before the incentive was implemented, bulk-billing rates for diagnostic imaging were growing quite strongly at the time. What we saw was diagnostic imaging bulk-billing rates continuing to increase but, from memory, at about the same rate or even tailing off slightly following the introduction of the incentive. But we will need to find that. So there was continued growth in bulk-billing after the incentive was introduced, but there was not a one-off, upward kick up in the bulk-billing rate at that time.

Senator REYNOLDS: So the rate of increase was pretty similar to the rate of increase before the rebate?

Mr Stuart: Pretty similar.

Senator REYNOLDS: So, arguably, whatever the taxpayer spent on that, it did not actually increase any more than the—

Mr Bowles: It did not change the trajectory of what was happening.

Senator REYNOLDS: It did not change its trajectory. It will be very interesting to see how much money was thrown at that. Were bulk-billing incentives paid to the patient or to the provider for this one?

Mr Bowles: It is to the provider.

Senator REYNOLDS: So will there be any changes to a patient's Medicare rebate as a result of this measure?

Mr Smith: No.

Senator POLLEY: Reforms to the Prostheses List were announced in *The Australian* today. I assume the department is aware of that. It is another coincidence that it was made

today. Are you aware of any exchanges about the timing of this announcement? Was it decided that it should coincide with estimates today? One can be a bit cynical about these things.

Mr Bowles: I am a public servant, and when things are announced are the decisions of ministers and governments. We can answer your questions on what we know about the changes, although they have been articulated in the media, as you have described.

Senator POLLEY: I think we can take it that it was an attempt, that did not work, to distract from the cuts. The reforms came in at $86 million per year. What will that mean for private health insurance premium increases in percentage terms?

Mr Bowles: That is a matter for private insurers but—

Senator POLLEY: So you have no idea whether the premiums are going to go up?

Mr Bowles: No. This is a yearly process that happens. Insurers will go away and do their number crunching, as they should. They will come back, as is their need, to government with an increase, which in the usual course of events will be announced or decreed in the new year.

Senator POLLEY: So you have no idea, then, how the government will ensure that the insurers pass on these savings? You would not have given any advice to the government about what needs to happen to ensure that the savings are passed on by the insurers?

Mr Stuart: There is a usual process of scrutiny over—

Senator POLLEY: This is new for me, so—

Mr Stuart: percentage increases, which involves not only the department but an independent agency called—

Ms Jolly: The Australian Prudential Regulation Authority.

Mr Stuart: APRA.

Mr Bowles: APRA look at this and give a view.

Senator POLLEY: Well, my understanding—

Mr Stuart: Then there is advice to the minister and it is then the minister's role to approve or not approve the various increases that are asked for. Obviously, the minister and the government have made these changes in the hope and expectation that providers will work hard to pass them on and that there will be a lesser increase than there would otherwise have been. What those increases actually are will be scrutinised by the department and APRA and advised to the minister.

Senator POLLEY: Right. Some people were expecting the cuts to be closer to $800 million a year. There is quite a difference between $86 million and $800 million. That would have been taken into consideration, I assume, by the department with their advice.

Mr Bowles: Let us get the context right. You cannot compare $86 million to $800 million. The $800 million, I think, is over a longer period of time and the $86 million is a one-year effect. I think the $86 million grows to something like a $500 million figure over the next five years. Again, I think you will find that the minister said this is a first step in quite a look at private health insurance.

Mr Stuart: That is $500 million over the next six years.

Senator POLLEY: Sorry; I missed that.

Mr Bowles: It is $500 million over six years, is it?

Mr Stuart: Yes.

Senator POLLEY: Savings of $500 million?

Mr Bowles: Yes. The $86 million is a yearly figure. I saw that $800 million reference somewhere else. It is a longer term figure, but if you look at this over the six years that Mr Stuart just referenced it is around $500 million.

Senator POLLEY: Couldn't the minister have saved policyholders much more money?

Mr Bowles: Again, this is step 1 in a broad look at private health insurance. The minister has made that very clear.

Senator POLLEY: Some could say, though, this is another case of the minister putting profits before patients.

Mr Bowles: I am not going to enter into a conversation that is political in nature in relation to what I think the minister intended in that context.

Mr Stuart: There is a further process that the minister and the government have already set in train, and that is to put in place a renewed Prostheses List Advisory Committee with a new chair, Professor Terry Campbell, who comes with a long history in the Pharmaceutical Benefits Advisory Committee. That committee is being asked to look at differing ways to make the cost of prostheses in Australian much more transparent and to look at possible ways of bringing prosthesis costs down over time in line with increased transparency, possibly through using vehicles like price disclosure, which have been used in the pharmaceutical benefits area for a number of years now. The minister's announcement of this morning is step 1, and we are already working on step 2.

Senator POLLEY: Okay. You would be aware that there was another article that appeared in *The Australian*, on 19 September, regarding a meeting of the Prostheses List Advisory Committee on 29 March. Were any of your officers at that meeting, Mr Secretary?

Mr Stuart: A meeting of the Prostheses List Advisory Committee?

Senator POLLEY: Yes, on 29 March.

Mr Stuart: I think you might be referring to a different committee.

Mr Bowles: If you are talking about the PLAC: yes, there would have been officers at that meeting.

Mr Stuart: But we did not meet on that day.

Mr Bowles: I don't think it would be the Prostheses List Advisory Committee that you are talking about.

Senator POLLEY: I will just try to check the facts of that and come back to it.

CHAIR: It is 1.15. The committee will break and resume at 2.15 pm.

Proceedings suspended from 13:15 to 14:15

CHAIR: The committee will resume examining program 4.1.

Senator POLLEY: We touched on whether or not you had any officers at that meeting, which I am led to believe was of the Prostheses List Advisory Committee on 29 March. You are saying that you are not aware of that meeting?

Mr Bowles: We did not have a PLAC meeting. That is a formal one of our meetings that looks at prostheses. You might be referring to other working groups we had meeting there. Maybe if you explore the issues and we will see where we go.

Senator POLLEY: That sounds good to me. According to the report, the then CEO of the Medical Technology Association of Australia held up her phone saying that she had a text message from someone in ERC and that the health minister had submitted a proposal to cut the prostheses list. Did the then CEO of the association say that? That is apparently what has come out of that meeting. You are still saying that is not a meeting that you are aware of?

Mr Bowles: That meeting was not a meeting of the PLAC, which is a formal health technology style of committee that we run around prostheses listing and prices.

Senator POLLEY: But you are aware—

Mr Bowles: I am aware of the article you refer to—which I think was in *The Australian* and might also have been in the *Canberra Times;* it was no doubt a syndicated one—about Susi Tegen and the MTAA. Yes, I am aware of that.

Senator POLLEY: Did the minister take a proposal to cut—

Mr Bowles: I am—

Senator POLLEY: You do not know. You did not give any advice in relation to that, going into that meeting?

Mr Bowles: There are two issues: I am not confirming or anything what Susi Tegen did in that meeting; that is not for me to do. And what the minister takes to cabinet or ERC, or however it was proposed, is the minister's business, not mine. I cannot really comment on what she takes through into a cabinet related committee.

Senator POLLEY: You were not asked to give any advice preceding that meeting in relation to cutting the list?

Mr Bowles: No. This meeting was a meeting to talk about prostheses more broadly and pricing and the whole structure of prostheses. That was the meeting. I think it was chaired by Lloyd Sansom. But that was a process-style meeting. A number of departmental officers would have been there. I am not aware that Susi Tegen did do what is alleged in the paper. None of my officers were aware of the obvious nature of that. I am sure there were a whole lot of conversations about prostheses and whatever was going on at that particular meeting. I have actually started an internal process, from my own perspective, on some of those allegations in the media, because I do not believe everything I read in the paper, so I ask for—

Senator POLLEY: But you would not discount them either?

Mr Bowles: I am not going to go there either, but I want to have a look at what was our procedural nature. I am not looking at whether there was a leak or not a leak. That is not my job. I do not look after those sorts of things. That would be something for PM&C.

Senator POLLEY: But you can confirm that you had officers there at that meeting?

Mr Bowles: Yes.

Senator POLLEY: How many officers were there?

Mr Bowles: I would have to take that on notice. There would have been a couple of people there. We were probably supporting that working group looking at prostheses.

Senator POLLEY: According to that report, which was in *The Australian* on 19 September, one of the officers cautioned the meeting against discussing issues that were in cabinet in confidence. To your knowledge, did they?

Mr Bowles: I do not know at this stage. It is subject to that internal review of mine, and I do not want to pre-empt the outcomes of that review.

Senator POLLEY: When did you start that review?

Mr Bowles: Not long after the article.

Senator POLLEY: When do you expect to conclude your investigation?

Mr Bowles: I hope it would be soonish—hopefully, by the end of this month.

Senator POLLEY: If that meeting took place on 29 March—

Mr Bowles: Well, yes—

Senator POLLEY: it has been a lengthy investigation.

Mr Bowles: No, it hasn't, because—

Senator POLLEY: You only started after the 19th?

Mr Bowles: The allegations only happened in September. I was not aware of them until that particular article.

Senator POLLEY: Would you be able to provide that on notice? I expect that you will conclude that investigation before the next estimates.

Mr Bowles: I probably will. I will take on notice whether it is appropriate or not for me to provide internal reports to this committee. If not, I am sure you will ask me a question at the next estimates and I will answer you around whatever findings I might have at that particular point.

Senator POLLEY: I would appreciate that. Thank you. Would it be worrying—I would have thought so—to the department that the health industry players had such access to those sorts of inside workings of the government? Does that raise concern? Is that still part of your investigation? And you will come back to me on that?

Mr Bowles: I am not saying it happened in the way it is described in the media. I have seen a lot of things described in the media where I have actually attended and it was not what I saw. So I am not ascribing anything to that. It is not a normal practice, let me say, that you would divulge issues like that. But I am not suggesting for one second that that was what happened, because I do note in the article that Ms Tegen also said that that is not true. She said something about a lot of conversations going on in that room.

Senator POLLEY: Can you, for the benefit of the committee, explain to me what you are then actually investigating?

Mr Bowles: I am looking at: were the appropriate checks and balances in place from our perspective? And is someone able to advise me that some of these things were at least voiced in the room, or was it one way or was it multiple ways, because there are multiple versions of the truth in the media article. I am not looking at the issue of leaking those sorts of cabinet related documents; that is not my role.

Senator POLLEY: Can you tell me whether Prime Minister and Cabinet are also investigating whether there was a breach of protocol?

Mr Bowles: I am not aware.

Senator POLLEY: Minister, are you aware of whether PM&C are investigating these leaks?

Senator Nash: No, I am not, Senator.

Senator POLLEY: Would you be able to take that on notice for us, please?

Senator Nash: Yes.

Mr Bowles: It would be a question best put to PM&C, of course.

Senator POLLEY: They have already been and gone.

Mr Bowles: You can still put a question on notice to them.

Senator POLLEY: That is a good idea. Thank you for that advice.

Mr Bowles: I am always helpful, Senator.

Senator POLLEY: You always are, absolutely. This health department is a learning experience for me. There are so many potholes here. During the campaign, the minister claimed that Labor's policy to remove the private health insurance rebate from junk policies could affect millions of Australians. Did the department ever give her any advice to that effect?

Mr Bowles: Specifically in relation to the ancillary side of things? Is that what you are talking about? Is that right?

Senator POLLEY: Yes.

Mr Bowles: We would have provided a whole lot of advice across a range of broad issues within the private health insurance domain. Again, that will be subject to government decision. That has not obviously come through. The government has decided with their phase 1 to look at the cuts to prostheses announced this morning. And, as I think Mr Stuart mentioned earlier, we have a revised PLAC under a new chairmanship as the formalised health technology assessment process. We also have a sector-wide committee looking at health insurance more broadly. Those issues, I am sure, will be canvassed in the context of that group.

Senator POLLEY: If we take the PBO's health department data to determine that Labor's policy would affect 65,000 policy holders, can you explain the difference between the millions that the minister claimed and what the PBO said?

Mr Bowles: I am not aware of what the PBO said. I have not specifically seen that. I do not know the premise under which they actually did their assessments. PBO will do their assessment based on a certain methodology, which is not necessarily the same as what we would do, so you cannot always get lined up views. But, without seeing what the PBO said and without seeing some of these other documents, I cannot really comment any further.

Senator POLLEY: They say that they used your department's data to determine the figure of 65,000 policyholders who would be affected, whereas the minister claimed a million would be disadvantaged. Would you take that on notice and see if there is anything more you can add?

Mr Bowles: I am happy to take it on notice. I might add that if 50 per cent of the insurable population is insured—I do not know but let's say that is probably about 12 million; it is

probably actually higher than that—not everyone has hospital-only care, so thousands versus millions sounds more right to me. But let me take it on notice.

Senator POLLEY: That would be good because it was a bit confusing for me.

CHAIR: We will move to program 4.2, unless other senators have questions on 4.1. Senator Griff, my advice on prostheses—I will take some guidance here—is that it is under 4.8 in general terms, but I am happy to be corrected if that is the case. Secretary, were you going to say something?

Mr Bowles: I have some information to give Senator Reynolds under program 4.1, based on her questions before lunch.

Mr Smith: Going back to some questions you asked prior to the break, you were interested in the bulk billing incentive and how much that was. It is between $1.40 and $3.40 per episode that is bulk billed; the amount depends on the item and its setting.

Senator REYNOLDS: This is for pathology or diagnostics?

Mr Smith: It is for pathology. That is the incentive that is paid to the provider. In relation to diagnostic imaging, those incentives commenced in November 2009 at the same time as the pathology incentives. To November 2015, $1.3 billion was paid as incentives in relation to bulk billed services.

Senator REYNOLDS: This was paid to providers?

Mr Smith: It was paid to providers, yes.

Senator REYNOLDS: And what was the impact on bulk billing?

Mr Smith: The annual growth rate in bulk billing prior to the measure was 2.7 per cent on average. Since 2009-10, the growth rate in bulk billing has been 2.6 per cent on average.

Senator REYNOLDS: Can I just get this right. The previous government spent $1.3 billion to grow bulk billing, and it actually went from a 2.7 per cent increase down to a 2.6 per cent increase?

Mr Smith: Just to clarify, it is the growth rate in bulk billing. Bulk billing continued to grow at a rate of—

Senator REYNOLDS: But at a lower rate than when it started?

Mr Smith: That is correct. It was slightly lower.

Senator REYNOLDS: A wildly unsuccessful use of taxpayers' money! Thank you very much.

Mr Bowles: On the issue of 4.4 versus 4.8, prostheses come under private health insurance. Program 4.8 is mainly just about the aids and appliances issues that we deal with, not the prostheses.

CHAIR: Okay. It is 4.4 for prostheses?

Mr Bowles: Yes. All the officers are here.

CHAIR: We will stumble our way through.

Mr Bowles: We will work it through.

[14:28]

CHAIR: Thank you. We will move to program 4.2—hearing services.

Senator SIEWERT: First, I would like to ask some questions about the review that I understand is currently being undertaken of the program and the services that the office provides. Are you able to update me on where that process is up to?

Ms Garrett: I presume you are talking about the work that is being undertaken as part of the NDIS transition. There are a number of work packages that are in progress that are aimed at ensuring a seamless transition to the NDIS when it is at full rollout in mid-2019. One package of work is the review of service items and fees. That is at the stage of information gathering. We have consulted with stakeholders, and that is pretty much where that is up to.

Senator SIEWERT: That is the review of services and fees?

Ms Garrett: Service items and fees, yes.

Senator SIEWERT: I will come back to ask questions about the consultation shortly. Can you go on with the other work that is being undertaken.

Ms Garrett: The other piece of work that is in its initial stages is the review of device supply arrangements. Again, that is in its very initial stages. During the consultation, stakeholders told us that they would prefer that those pieces of work were consulted on together, and that is what we are looking at.

Senator SIEWERT: Those are the two areas of review of work that you are undertaking.

Ms Garrett: Of work at the moment, yes.

Senator SIEWERT: Have you got a list of your stakeholders that you consulted, rather than taking up time with you reading them out?

Ms Garrett: Yes. I am happy to provide that on notice.

Senator SIEWERT: Could provide a list of stakeholders consulted. What was the nature of the consultation?

Ms Garrett: That was an information gathering session. Stakeholders were consulted in either groups or individually. It was aimed at gathering views on that piece of work, so it was very initial.

Senator SIEWERT: When you say views, that is on both the devices and the services?

Ms Garrett: The information gathering has only been on the service items and fees.

Senator SIEWERT: Will you be going out to consult further on the devices?

Ms Garrett: Yes. We will consult on all of the work packages.

Senator SIEWERT: When you say information gathering, what sort of information were you interested in gathering and what sort did you get? The two are not always the same.

Ms Garrett: We have not put together a report from that. That is being synthesised. We were seeking views from stakeholders as to whether or not they found the current schedule of service items and fees complex, and whether or not there was an opportunity to refine that or streamline it.

Senator SIEWERT: What is your initial feedback on that?

Ms Garrett: The views varied.

Senator SIEWERT: On whether they were complex or not?

Ms Garrett: Yes.

Senator SIEWERT: Will you have to go out again to consult on devices?

Ms Garrett: Yes. We will do some information gathering and then we will put together a consultation document which covers both of those pieces of work.

Senator SIEWERT: What happens from there?

Ms Garrett: From there we will start to factor that in with the other pieces of work that we will need to do for NDIS transition. There is quite a lot of work to be done.

Senator SIEWERT: I understand that. That is why I have a lot of questions. You will then hand that over. I will be asking NDIA tomorrow about a whole lot of these issues. In terms of your work from here, what is the time line for finishing that process?

Ms Garrett: We are working through a process to get through all of the work or the activities that we need to do in order to be ready for the NDIS rollout in mid-2019. Our time frames are related to that rollout. We would like to consolidate some of that, so that we minimise the burden of consultation on our stakeholders. We will go out to consultation on a number of items together rather than separately.

Senator SIEWERT: The devices, the services and the fees—are there other issues that you will be going out on?

Ms Garrett: We will be looking through a whole range of issues that have been raised by stakeholders as areas of concern in the transition to the NDIS.

Senator SIEWERT: Do you have a list of those issues of concern that you could give to the committee?

Ms Garrett: The transition plan for the Hearing Services Program to the NDIS was published earlier this year.

Senator SIEWERT: It is basically what is in there, is that correct?

Ms Garrett: That is exactly right.

Senator SIEWERT: It is not different to what is in there?

Ms Garrett: No.

Senator SIEWERT: I want to go back to double-check the key findings. I know you said you have not pulled it all together again. What is the time line for looking at what the key findings from this initial round are?

Ms Garrett: It will be early next year.

Senator SIEWERT: Will that be publicly available?

Ms Garrett: The consultation will be public.

Senator SIEWERT: The report on the consultation?

Ms Garrett: The discussion paper for consultation will be.

Senator SIEWERT: I think people were expecting the discussion paper to be sometime this year. It sounds like that is going to be put off now until next year?

Ms Garrett: Yes, and that is because of the feedback from stakeholders who did not want to not be consulted separately on each piece of work.

Senator SIEWERT: So, as you said, that is the reason for combining them all?

Ms Garrett: Yes.

Senator SIEWERT: Do you have terms of reference for the actual process?

Ms Garrett: No.

Ms Jolly: The plan is on the website.

Senator SIEWERT: So that is going back to that previous issue. That is the terms of reference?

Ms Garrett: Yes.

Senator SIEWERT: You have already taken on board the list of stakeholders. If you do not have all of them and there are people and organisations that wish to be consulted, can they be included in the process?

Ms Garrett: Yes.

Senator SIEWERT: Is there going to be an advertisement with the discussion paper? Prior to that, what is the process? Then is going there going to be a formalised round of consultation on the actual discussion paper?

Ms Garrett: There will be a formalised round which will be advertised by the department's website, and we will write to as many stakeholders as we know would be interested.

Senator SIEWERT: Yes, there is a long list. That is on the discussion paper. Prior to that, in terms of the initial next round of information gathering on devices, for example, if people want to chuck their name on the list, can they?

Ms Garrett: Yes.

Senator SIEWERT: Presumably there is a contact on your website for that.

Ms Garrett: Yes, there is.

Senator SIEWERT: Has there been any discussion on what the minimum level of hearing loss required to access the new program, the NDIA, is going to be?

Ms Garrett: We are waiting on the NDIA to finalise the eligibility criteria, which that would be a part of, so that is really a matter for the NDIA.

Senator SIEWERT: I accept your answer partly. But have they consulted you on that? You have a certain level of expertise in the office. I mean that as a compliment. I do not mean that as a minimum level; I mean that you do have a level of expertise.

Ms Garrett: Yes, they have talked to us.

Senator SIEWERT: So you have had input into that, but you do not know what their final decision is.

Ms Garrett: That is correct.

Senator SIEWERT: This may be a question for the minister. What happens if people are not happy with the level of hearing loss that is finally determined by NDIA, particularly if it differs to the one that is currently being used? What happens then?

Senator Nash: It not being my portfolio anymore, I am very happy to take that for you on notice, but I just do not have that detail.

Senator SIEWERT: I will obviously follow it up tomorrow, but I figured it goes back to the—

Senator Nash: Absolutely. I am happy to try and get you an answer—hopefully, before the end of the day, if I can.

Senator SIEWERT: Thank you. Are you able to share with us what your recommendations were for the level of hearing loss?

Ms Garrett: No, I do not think so. That is a matter for the NDIA.

Ms Jolly: We say we have been consulted; we have been sharing data and information about our clients and what we know about our clients, in assisting the NDIA to come to a determination on eligibility. It is not that we have put forward a particular view.

Senator SIEWERT: So that is the extent of your involvement in the discussion with the NDIA about the level of hearing loss? In other words, you are telling me to go and talk to the NDIA?

Ms Jolly: Well, it is really a matter for them. Obviously, the eligibility criteria will then determine part of the transition arrangements between now and mid 2019-20.

Senator SIEWERT: The rules still apply, don't they? If they are already receiving services, they will still continue to receive services even if there is a different level used?

Ms Garrett: Yes.

Senator SIEWERT: You will be aware that there is a level of discontent in the hearing impaired community about some of the issues around contestability. Have you had any discussions about a different form of approach for hearing and hearing services?

Ms Jolly: Most of our discussions have been around the transition to the NDIA and the model that they are rolling out, so we have not had any independent or different analysis about the program itself.

Senator SIEWERT: During those previous discussions—the information gathering—were the issues about contestability in the hearing space raised with you?

Ms Garrett: Not during the information gathering, no. That was primarily focused on the service items.

Senator SIEWERT: From what I could tell from your body language earlier and your nodding, they had definitely been raised.

Ms Jolly: Certainly the issues have been raised with us, but not, as Ms Garrett said, in the formal consultations that we had.

Senator SIEWERT: Is there a joint team between yourselves and the NDIA? How are you organising the transition?

Ms Garrett: There are a number of different committees that the Department of Health, the NDIA and the Department of Social Services are on together to work through those transition arrangements.

Senator SIEWERT: A number of committees?

Ms Garrett: Yes, that is right. There is a communication steering committee and there is a governance group.

Senator SIEWERT: That is for the transition overall?

Ms Garrett: Yes.

Senator SIEWERT: Sorry, I am thinking specifically about hearing.

Ms Garrett: There is a governance group for hearing.

Senator SIEWERT: Where is that located? Is it in the department?

Ms Garrett: It is in the Department of Social Services.

Senator SIEWERT: And you are on that?

Ms Garrett: Yes.

Senator SIEWERT: How many people from your office are members of that?

Ms Garrett: That would depend on the meeting, the agenda and those things, but it is common practice to work across on these sorts of matters. We would be around the table, and if we were talking about a particular issue there might be others from the Office of Hearing Services with particular information who might come along to those meetings. Who attends really would depend upon exactly what is being discussed. It is not limited.

Senator SIEWERT: It is not prescribed.

Ms Garrett: No, it is not prescribed.

Senator SIEWERT: Is there a way for that team to consult with consumers?

Ms Garrett: That committee is run by the Department of Social Services.

Senator SIEWERT: So you are telling me I should ask them tomorrow. Some issues are already starting to be raised around the role of the NDIA, and I will traverse some of this tomorrow with them, but issues around newborn hearing screening and response have been raised with me. As you know, babies need cochlear implants very early, once the need has been identified. You get them in by the time they are six months old. I am being told that, because of the new process and issues around contestability et cetera, it is taking longer than six months to traverse the system. So, one has to ask: what is the point of newborn screening to obtain that early intervention, if now we are seeing a situation where it is taking longer than six months to get that early intervention?

Ms Jolly: The current arrangements for the hearing program have not changed.

Senator SIEWERT: They have in some states.

Ms Jolly: In terms of the NDIA arrangements for new clients, you really have to talk to the NDIA about their processes.

Senator SIEWERT: In South Australia it has changed—that is being reported to me from very reliable sources. Has that been raised with you?

Ms Garrett: Certainly concerns about how that early referral pathway will operate in the future have been raised.

Senator SIEWERT: So there are two issues. There is the most immediate, which is going to take a long time, from the experience that is already happening. And then there is how that is being handled. I understand that you are not aware of the actual examples, but have you responded to the scenarios that people are pointing out?

Ms Garrett: No, we have referred them to the NDIA when they have been raised with us.

Senator REYNOLDS: Secretary, can you advise me how many new listings have been announced since the coalition came to government in October 2013.

Mr Bowles: I will get my able colleagues to help you.

Ms Shakespeare: Senator, your question was on the PBS listings since—

Senator REYNOLDS: October 2013.

Ms Shakespeare: The number of new and improved listings since that time is 1,162.

Senator REYNOLDS: That is 1,162 new listings?

Ms Shakespeare: New or amended PBS listings.

Senator REYNOLDS: What has been the cost of these listings since October 2013?

Ms Shakespeare: The total listing cost of those based on public prices and PBS list prices is $4.4 billion.

Senator REYNOLDS: So it is 1,162 new and amended listings at $4.4 billion. How does that compare to the comparable period three years earlier than that?

Ms Shakespeare: I am sorry; I do not have that information.

Senator REYNOLDS: Could you take that on notice. So you do not know how much, but do you have a schedule year by year of how many new listings there have been? Do you have that available?

Ms Shakespeare: We would certainly produce information on the number of new and amended listings each year. We include that sort of information in our annual report. As to whether or not that has been collected on a comparable basis and how far back that goes, we will have to have a look.

Senator REYNOLDS: Could you have a look at that and take it on notice with a view to coming back with the information during the course of the hearing today. I would have thought you would have been able to identify new listings every year.

Ms Shakespeare: We would need to check that in our annual reports. I am not sure that we will be able to do that today.

Senator REYNOLDS: Do you know if the rate has increased? Do you have any sense of trends in the number of new listings year by year?

Ms Shakespeare: I think we would need to check that through the data.

Senator REYNOLDS: I would like to go on to hep C. How many patients have commenced treatment with the hep C medicine under the PBS since 1 March this year when it was introduced?

Ms Shakespeare: Our most up-to-date figures from the dispensing information we get from the Department of Human Services are that there have been about 25,000 individual patients.

Senator REYNOLDS: Since 1 March this year alone?

Ms Shakespeare: That is correct.

Senator REYNOLDS: Wow! That is extraordinary. Do you have any idea how many of them have now completed their course of treatment? It is a finite course.

Ms Shakespeare: I think a rough estimate at this stage based on what we know about the length of treatment is probably about 5,000. But that is quite rubbery.

Senator REYNOLDS: So 25,000 people are already on that course of treatment and 5,000 have finished. Do you have any idea of the downstream benefits of this treatment for people's health outcomes and the cost of treatment to the Australian taxpayer?

Mr Stuart: This is really one of those fantastic things that you have an opportunity to be associated with in your career. This medicine is really a game changer for hepatitis C. We have already seen more people treated effectively this year than we would have ordinarily seen treated over a number of years. There are about 230,000 people in Australia infected with hepatitis C, about 700 deaths a year attributable to hepatitis C and also a significant feed through from hepatitis C to liver transplants. So we are expecting to see over a number of years a very significant reduction in the pool of infection in hepatitis C, a reduction in deaths and a reduction in transplants and in downstream health system costs. We have an opportunity, if everyone plays their part, to actually all but eradicate the disease in the course of a generation.

Senator REYNOLDS: Really? Wow. That is indeed very good news. If it was not on the PBS, what would it cost somebody to go on this course of treatment?

Ms Shakespeare: Probably the best estimate is looking at the public price now on the Pharmaceutical Benefits Scheme for these medicines. There are different medicines listed, but it is in excess of $20,000.

Senator REYNOLDS: Is that $20,000 per dose or per course of treatment?

Ms Shakespeare: Per course of treatment.

Senator REYNOLDS: And how much do they pay now?

Ms Shakespeare: For patients it will be the applicable PBS co-payment amounts, which is $6.20 for concessional patients and $38.30 for general patients.

Senator REYNOLDS: So instead of being $20,000 per patient, now 25,000 people are paying either $6.20 or $38.30. That is a very good news story indeed.

Senator DI NATALE: I have some questions on the Life Saving Drugs Program and the report. When was the review initiated for the Life Saving Drugs Program? It feels like it has gone on for more than a year.

Mr Stuart: It was a couple of years ago.

Ms Shakespeare: It was announced on 9 April 2014.

Senator DI NATALE: And we still have not seen a report?

Ms Shakespeare: A report has been completed. It is being considered by government.

Senator DI NATALE: It is now more than two years since the report was initiated; is that right?

Mr Stuart: Since it was initially commissioned.

Senator DI NATALE: And we still do not have an answer about what is happening with the Life Saving Drugs Program?

Ms Shakespeare: There has been a post-market review of the Life Saving Drugs Program and a report of that review completed. The government is now considering the review.

Mr Stuart: That was of course punctuated by an election period.

Senator DI NATALE: I thought you might say that. Nitisinone was listed recently. Does that mean that the program is continuing as it always has under the same guidelines?

Ms Shakespeare: Yes.

Senator DI NATALE: Is there any move to try to roll the program into the PBS in some way? Is that the thrust of what is being proposed?

Mr Bowles: That would be a decision of government ultimately, but that does make some sense. There are broader policy implications, so we would need to consider that. Ultimately that would be a decision for government.

Senator DI NATALE: Do we have any sense of when we are going to get an answer on this?

Mr Stuart: We are working on this quite hard right now.

Senator DI NATALE: For two years?

Mr Stuart: We are working on this quite hard.

Senator DI NATALE: You can understand that there are a lot of patients who are very desperate who are currently being denied access to some drugs that are available overseas. It might not affect huge numbers of people, but it certainly affects reasonable numbers and they are people in very desperate situations. They have been hanging on this report for a long period of time. It seems that we have not got an answer as to how we are going to approach this obviously very difficult issue for government. Do we have a timetable for completion?

Mr Stuart: I hate to keep parroting this, but it is subject to a decision to government. We are working on this issue quite hard at the moment.

Senator DI NATALE: All right, I will not pursue that.

Mr Stuart: I saw a statement from the minister from the last couple of days where she told a group of people that it was at the top of her in-tray right now. The minister is currently very motivated to see this through.

Senator DI NATALE: I may have missed the boat on this: was the MBS review part of medical benefits?

Mr Stuart: Yes.

Senator DI NATALE: We can return to it later. I could ask a few brief questions about it now and put the rest on notice, if that is easiest.

CHAIR: Ask the brief questions and put the rest on notice.

Senator DI NATALE: Could you give me an update on the status of the review?

Mr Stuart: It is progressing very well. There is a large number of clinicians, health economists and consumers working on various working groups under the review. It is really gathering pace right now. There was, very recently, in the public arena a second round of recommendations from the review available for public comment. A large number of public comments were received, and now the task force and its working groups are going to consider those comments and provide advice to government.

Senator DI NATALE: Have all the six clinical committees made a set of recommendations?

Mr Stuart: There are quite a lot more than six, but I will ask Ms Jolly to outline that.

Senator DI NATALE: Perhaps you can explain it to me.

Ms Jolly: Are you talking about the first six committees?

Senator DI NATALE: Yes.

Ms Jolly: The reports that have just been out for consultation are from that tranche of committees. They are out and comments have closed. We have had 948 submissions on those recommendations.

Senator DI NATALE: What were the other committees that I am not aware of? You said that there were a lot more than six.

Ms Jolly: Since the first six, we have established further committees.

Senator DI NATALE: How many?

Ms Jolly: I can work you through those, if that is useful.

Senator DI NATALE: Just give me the total number, and, to save everybody's time, could you provide the total list on notice?

Ms Jolly: Sure. I am happy to do that.

Senator DI NATALE: How many are there in total now?

Ms Jolly: We have the six committees that have just recently released reports, we have a further six committees that are working on the next round of public and we are in the process of establishing some more. I will give you the full list.

Senator DI NATALE: Great, thank you. Have you made any specific recommendations already? Are you still waiting on removing some item numbers from the MBS, or is that premature?

Ms Jolly: Where we are up to in the process is that the committees have released reports, as I have said. We have had a significant number of submissions come in. Those will now be synthesised and will go back to the clinical committees for them to review. That information will then go through the task force, and the task force will make recommendations to the minister.

Senator DI NATALE: So the task force makes recommendations to the minister and the minister ultimately has final sign off.

Ms Jolly: Yes.

Senator DI NATALE: And a recommendation may be to remove some item numbers from the MBS?

Ms Jolly: Yes.

Mr Bowles: You might recall—I think it was budget—there were a number of items removed as obsolete items. That was the first round. This is the second round, and there will be other rounds.

Senator DI NATALE: Do you have a time line for when this will be completed?

Mr Stuart: There was never a fixed time line set. The process was funded for a two-year initial process. It is going to take longer than two years to complete, but it is really gathering pace.

Senator DI NATALE: How much has been spent on it so far?

Ms Jolly: I do not have that figure. Yes, I do, my apologies.

Mr Stuart: In terms of how much spent, we would need to take that on notice. There is a budget of $30 million over two years for this review and the usual work of MSAC taken together.

Ms Jolly: I do have those figures. In 2015-16, it was $17.037 million.

Senator DI NATALE: Is that on both MSAC and the committees?

Ms Jolly: That is on both, yes. Then we have an expected figure going forward.

Mr Stuart: Of a similar amount.

Ms Jolly: Yes, a similar amount.

Mr Stuart: That is both of these processes taken together.

Senator DI NATALE: You will not have the precise number, but is MSAC a small proportion of that total pool?

Mr Stuart: I do not think that is fair to assume, no. MSAC is quite a large effort which contracts out quite a lot of health technology assessment, so I think we would probably need to come back to you on notice on that.

Senator DI NATALE: Could you give us a breakdown on how much has been spent and what proportion on MSAC versus the MBS review?

Ms Jolly: Sure.

Senator DI NATALE: I will put the rest on notice.

CHAIR: Thank you very much, Senator Di Natale.

[14:59]

CHAIR: We move to private health insurance, program 4.4. Senator Griff.

Senator GRIFF: My questions relate to the prosthesis list and the overwhelming evidence from many in the health industry that the health prices are excessive, which I am pleased to see that the minister in her media release of today is tackling, albeit in a small way.

Being very much new to estimates—this being my first experience—and also to this portfolio, I would appreciate the department providing me in the first instance with a brief outline of the rationale behind the department setting reference prices instead of the market setting its own prices.

Mr Stuart: The prosthesis listing and pricing process has been in place for quite a number of years. My understanding in the mists of time was that the government became involved in this area at a time when prosthesis expenditure was accelerating very rapidly and that that was feeding through to government expenditure on the private health insurance rebate. That is a broad understanding of a piece of history from a number of years ago.

Senator GRIFF: Given the minister in today's release states that some medical devices have been inflated by thousands of dollars for private patients and given that the department actually sets the reference pricing, how did the department end up arriving at such inflated prices as described by the minister? How does that happen? How does that continue?

Ms Jolly: I can talk you through the current process. Until recently—it has just been re-established—there was the Prostheses List Advisory Committee. They considered applications from device manufacturers, including analysis of costs and benefits. That went through a process. The committee also had health economics advice, and then they arrived at a benefit amount.

Senator GRIFF: Are all device manufacturers able to participate in this? I understand that for sponsors there is this 25 per cent market share before they are able to, in a way, impact the reference pricing. Does that include—

Ms Jolly: It is an application based process. Then the prices are based in what you are talking about, which is bands. Your device is considered in a band—that is what you mean by 'reference pricing'—for similar prosthetic devices. Obviously, the market share will have an impact on the level of that for other companies.

Senator GRIFF: As I understand it, a manufacturer or a sponsor has to achieve 25 per cent share in order to impact that reference pricing.

Ms Duffy: The way that the benefits are set as already described is the category pricing, set some time ago when the government started to regulate benefits. If a device sponsor wants to seek an additional benefit, they do have to provide a submission, as Ms Jolly mentioned, and they also have to demonstrate their market share in terms of what impact that would have to overall prices if the prices all went up.

Senator GRIFF: And that is 25 per cent as the minimum requirement?

Ms Duffy: That is one component, yes.

Senator GRIFF: Is that not an impediment for small device manufacturers? Twenty-five per cent is a very large share.

Ms Jolly: That is just the current process.

Ms Duffy: It is the current process and, as Mr Stuart said, there is a new, revamped PLAC that is looking at a revised process that brings a greater level of transparency and consistency to the whole benefit-setting process underway.

Senator GRIFF: So the new process will be a fairer process in the sense that smaller device manufacturers can be involved.

Mr Stuart: I want to clarify that we do not set a 25 per cent threshold for access to the reimbursed market. I think there was a risk of being at cross-purposes there. One of the features of the current arrangements is that, provided the TGA says the device is safe and effective and the PLAC considers it to be of quality, it goes on the list, so we have quite-low-volume products on the list. We do not seek to limit the number of devices of a particular kind that can be on the list.

Senator GRIFF: Does the department review overseas prices and prices in the state system? There seems to be quite a variation between prices charged by states versus the list prices.

Ms Jolly: I think that goes to the new process, the new committee and the terms of reference of that committee to have a look at some of those arrangements. It is part of the general conversation of private health insurance reform.

Senator GRIFF: Again, being a new person, I just find it quite staggering that some devices sell for $52,000 in Australia compared to $15,000 in Sweden and $28,000 in Britain, some 107 or 329 per cent above prices overseas. It is quite staggering how we have actually got to that point. I am very excited about a new system going forward, but it seems an enormous amount of money has been, one could say, sort of wasted within the system over a lot of years up until the point where the new system comes into play.

One thing I also do not understand is that often you have a private patient in a public hospital being charged significantly more for the same procedure and implant using the same doctor and the same device. For instance, a coronary stent for a private patient costs $3½ thousand. In WA, the same stent in a public hospital costs $1,200. Components for a common hip replacement cost patients around $6,000, yet in the public hospital system the same component costs $4,000. Does the department consider that to be a fair system?

Mr Bowles: I do not think we would describe it in those sorts of terms. The public system works in a completely different way to the private system to start with. What the public system has is a nationally efficient pricing structure that enables the public sector to look at pricing of all components of care in quite a different way than the private sector actually do. It is actually seeing some quite positive changes over time in how things get priced. The other benefit, having worked in the public hospital system in a couple of states, is that the state hospitals have got together and looked at how they go to market for particular things, so it is a market power issue in some cases versus the much smaller markets in the private sector or individual hospitals. That is part of the problem with the overseas market as well: some of the market power issues come into play when prices are set. It happens across drugs, devices and a range of other things in the health sector. It is one of the difficulties we face when we are trying to do this, so that is why this new process around transparency of pricing, we hope, will actually help that.

Senator GRIFF: I am very excited about the new process, but it states that the proposed reforms will reduce cardiac devices and intraocular lenses by 10 per cent and hip and knee replacements by 7.5 per cent. There definitely appears to be significant scope to go much further than that. Surgeons that we spoke to today stated that cardiac pacemaker prices alone are inflated by up to 70 per cent, so 10 per cent does not really cut it. In fact, just one example quoted to me today is the pacemaker DRG F12B, which is charged at $14,000 at a private hospital versus $4,000 in public. That is a very significant variation.

Mr Bowles: Before you arrived I talked a little bit about some of these sorts of issues. This is sort of step one: looking at these particular devices because there are large numbers in these particular categories. The revamp of the Prostheses List Advisory Committee is another step. There is also a broader, sector-wide committee looking at private health insurance more broadly for what other reforms you could bring to the insurance sector to do this. Prostheses are just one part of that broader system, so we are only at step one. If you get transparency in pricing and start to deal with some of those sorts of issues, you would hope that you would actually see further improvement over time.

Senator GRIFF: I will look forward to it. With a handful of items here, the minister is stating that there will be an $86 million saving in the first year and up to $500 million over the next six years. Calculations by various people in industry and our own calculations from talking to people indicate that the potential savings are anywhere between $500 million or

perhaps $650 million or $700 million a year, which is very significant. Would you see this new process bringing about significant savings, more than just $86 million over a handful of items?

Mr Bowles: Over time, yes. If you take a holistic look at private health insurance over time, you have got to see significantly more than this. This is looking at prostheses in particular categories in a particular way. We do need to go further, and I think you will see changes over time. Clearly this is a private sector market, and we have to watch that we do not over-influence private sector markets. But, clearly, by trying to bring prices down in this space we can hope to have a proper impact on the overall pricing structures.

Senator GRIFF: So we could potentially have the savings that I indicated?

Mr Bowles: Yes.

Senator DI NATALE: Can I ask some general questions about coverage. Can you give us the most recent figures for the total coverage of PHI?

Ms Duffy: According to the data that is released by the Australian Prudential Regulation Authority, which collects directly from private health insurers, the total coverage is split up between hospital and general. In terms of total coverage, at June 2016 there were 13.4 million Australians covered, and that participation rate is 55.7 per cent.

Senator DI NATALE: Do you have a breakdown for hospital and general?

Ms Duffy: Yes. For total hospital treatment, participation was 47 per cent and general treatment was 55.7 per cent.

Senator DI NATALE: How does that compare with figures from previous years?

Ms Duffy: In the previous year, hospital was 47.4, general was 55.8 and total was 55.9.

Senator DI NATALE: So that is a drop in coverage?

Ms Duffy: It is a small drop.

Senator DI NATALE: Is that the first time we have seen a drop in coverage in recent years? When was the last time we saw a decrease in coverage?

Ms Duffy: I do not have that information; I would have to take that on notice.

Senator DI NATALE: But it would be fair to say we have not seen one in recent years. I think I have been doing this now for four or five years.

Ms Duffy: It has been pretty static.

Senator DI NATALE: I have asked that question pretty consistently, and it has been going up or has been static for the last five years; there has not been a decrease. Would that be a fair statement?

Ms Duffy: I will take that on notice.

Mr Bowles: I think you are right. It has been relatively stable over the last number of years, but slightly changing.

Senator DI NATALE: Do you have any explanation for why you think it might have dropped a bit?

Mr Stuart: I think, as you are aware, the minister had a survey seeking views about reform of private health insurance, and there was a fairly widespread set of information back

to her from about 40,000 people talking about value for money and price increases and gaps and things of that kind, and information available.

Senator DI NATALE: So you feel all those things have probably contributed to people being less satisfied with the product?

Mr Stuart: I think you could draw that conclusion.

Senator DI NATALE: That is total coverage. What about people who are downgrading their policies? Do you have information on that—exclusions, restrictions et cetera?

Mr Bowles: I think it goes to all of those same sorts of issues—poor value for money, I suppose, people will say.

Senator DI NATALE: But, in terms of the numbers, do you collect data on the range of policies—I do not know how you actually categorise those—and shifts? That is obviously a very blunt measure. If we look at it in more detail, are we seeing people downgrade the level of cover they have?

Ms Duffy: APRA provides data on policies that have exclusions or non-exclusions, in terms of hospital policies. As at June 2016 the total number of policies that were exclusionary was 2.1 million.

Senator DI NATALE: So 2.1 million Australians had policies with no exclusions—did I understand that correctly?

Ms Duffy: That had exclusions.

Senator DI NATALE: That had exclusions.

Ms Duffy: At the same time, in 2015 it was 1.9 million.

Senator DI NATALE: That had exclusions?

Ms Duffy: Correct.

Senator DI NATALE: Sorry, what years were they?

Ms Duffy: In 2015 and in 2016.

Senator DI NATALE: So that is just from year to year. Was the 2.1 figure the most recent figure?

Ms Duffy: Correct.

Senator DI NATALE: But it was 1.9 before, so we are seeing a significant jump in the number of people who are taking up policies with exclusions—in other words, downgrading the level of cover that they have.

Ms Duffy: Changing or amending.

Senator DI NATALE: Is that the only sort of figure that you have got to get to that information around the level of cover? Is it just defined by exclusions or do you have any other—

Ms Jolly: Can I just clarify that the June 2015 figure was 1.97, so it is closer to the two—

Senator DI NATALE: 1.97 versus 2.1—but that is still a fairly big jump.

Ms Jolly: But there is still a change.

Senator DI NATALE: That is hundreds of thousands of people who are opting to take a policy with more restrictions or more exclusions.

Mr Stuart: This is obviously part of what is feeding into the government's wish to found a new committee and undertake some policy work in this area.

Senator DI NATALE: That is a good thing. It is long overdue. So we have seen less coverage overall and more people opting to take the policies with exclusions. What is the rebate worth now?

Ms Duffy: At the moment, in terms of the budget that is set for this year, it is estimated to be $2.649 billion.

Mr Stuart: Hang on a sec.

Senator DI NATALE: No, that cannot be right. It is probably going to be more like $6 billion or $7 billion.

Mr Stuart: It was $6.2 billion last year.

Ms Duffy: Sorry.

Senator DI NATALE: So what is the current figure?

Mr Bowles: It is around $6.2 billion.

Senator DI NATALE: $6.2 billion this year? The most recent data that you have got is that it is $6.2 billion?

Ms Duffy: Yes.

Mr Bowles: Yes.

Senator DI NATALE: And what was it in the previous financial year?

Ms Duffy: Last financial year it was $5.9 billion.

Senator DI NATALE: So an extra $300 million, in ball park figures. So we are spending an extra $300 million on a product that people are dissatisfied with, and they are downgrading their cover. We are seeing prostheses cost two, three or four times what they might cost in other areas. Do you think that we are getting good value for money out of the rebate?

Mr Bowles: Consumers themselves have said that it is poor value for money. That is why they are probably changing their view and that is why the government is actually looking at different ways of looking at this into the future with the sector committee and the new PLAC committee.

Senator DI NATALE: I would like to go to the prosthesis issue. I think the minister said that she now hopes that the changes that are being made will put downward pressure on premiums. The saving is $86 million per year. Is that right?

Mr Bowles: Yes, that is right.

Senator DI NATALE: There are 13.4 million people who have cover. If we average it out per person, that is $7 off the cost of a premium per year?

Mr Bowles: It depends on who has what cover and all sorts of things—

Senator DI NATALE: Yes, I know, but just as a ball park figure. What is the average increase in premiums? Doesn't it go up by about six per cent?

Mr Bowles: About six per cent.

Senator DI NATALE: What is the average premium worth?

Mr Bowles: We would have to take that on notice.

Ms Jolly: It would be very hard to determine what an average premium product would be because it would vary according to quite a lot of factors.

Senator DI NATALE: I am talking about an average: just the average cost per premium.

Ms Jolly: We will take that on notice.

Senator DI NATALE: I suppose the point is that we are talking about a product that costs maybe $1,000 per person, as a ballpark figure. The six per cent increase in the cost of those premiums is $60 and we might save $7 on the prosthesis. We are still going to see a significant increase in premiums next year if current trends continue. There is no reason to think that they will not.

Mr Bowles: If you look at history, you would see that premiums have been growing at around that six per cent mark for a period of time. This should put downward pressure on rates, but it will not necessarily take them down to one per cent or to four per cent. As I said, this is the first part of a broader set of reforms in the whole PHI space.

Senator DI NATALE: We do not want to create false expectations for consumers—it is a good thing that we are doing some work on the prosthesis list—but we are talking about a very modest saving in premiums, possibly $6 or $7 per person who has private health insurance. We would expect to see premiums go up in the order of hundreds of dollars for a family if current trends continue.

Mr Bowles: I suppose you have to start somewhere. This is the first step in looking at private health insurance reform. The figure of $86 million a year is still a significant amount of money. Yet, when you take it down to a per individual amount, it is still putting downward pressure and it is a sign or a signal to the community that we want to put downward pressure on rates. Clearly, they have been going up and that is why government has been looking at it.

Senator DI NATALE: We often hear that the private sector is more efficient in terms of delivering services. We hear that sometimes from some of my colleagues in the health sector. Why is it that a prosthesis costs so much more in the private sector than it does in the public sector? Can you explain to people who might be listening in, what the underlining structural—

Mr Bowles: I touched on this before. It depends on how we are comparing things.

Senator DI NATALE: I am comparing public to private.

Mr Bowles: Yes, and that is what I touched on before. The public sector has quite a different structure. It has a nationally efficient price which puts price pressure on the overall cost of care. That is not the same in the private sector—that is the first point. Then there is also market size. There is the ability in the public sector to go for contracts across hospitals and sometimes across area health services and across states—so contracts for items. They limit products, drive efficiencies and get better value for money. The same cannot said in the private hospital sector at this point in time. That is the big difference.

Senator DI NATALE: What is the public policy rationale for channelling—what is now an extra $300 million—$6.2 billion into the private sector? If we were spending that money directly on services within the public sector, we would have a whole lot more people getting access to things like hip replacements and knee replacements, would we not?

Mr Bowles: I think it is not a fair question to ask a public servant about policy provisions. The policies have been there for a long period of time now. The rebate is not a new thing. If we have a sector wide committee that starts to look at insurance, in its broad sense, you are going to deal with insurers and private hospitals. You will also deal with device manufacturers and the pharmaceuticals world, and you will actually deal with public hospitals because they do have a role.

Senator DI NATALE: I think there was some commentary about reforms looking at gold, silver and bronze policies within the health insurance sector. Has the department done any work on that?

Mr Bowles: Mr Cormack can talk a little bit about that.

Mr Cormack: We are looking at supporting the government's whole package of reforms in private health insurance. I think the focus today has clearly been on today's announcement around prostheses—it is an important element. The work of the Private Health Ministerial Advisory Committee will look at all elements of the private health insurance product. It is based on the extensive consultation that was undertaken last year. You have reflected some of those community dissatisfactions with the product. So it looks at product design and that recognises that there is a need to simplify the descriptors and for a much smaller range of product types, and that will necessarily take into consideration the concept of gold, silver and bronze, for example, as one way of describing three similar sorts of products so that consumers are able to make their choices based on similar products. What might be out there in the marketplace at the moment as gold or top cover from one company is not the same from another company. This is a very important piece of work, and the Private Health Ministerial Advisory Committee will progress that.

We will also look at more consumer information, including provisions to make more informed choice around initial choice of products and renewals. It will focus on regulatory aspects—and we have spent quite a bit of time this morning talking about the obvious regulatory issue around prostheses, which is a sort of regulated benefit level. It will focus on affordability and transparency with a particular focus on rural and remote consumers who necessarily have less choice to access private services because they are less prominent in rural and remote areas. And it will focus on a range of other areas to improve the overall product. So I think it is important that the focus that we have had today on prostheses be put in the context of a wholesale piece of policy reform that will be undertaken over the coming months.

Senator DI NATALE: Can you explain again the gold, silver and bronze, and how you are grouping products into each of those categories?

Mr Cormack: This is very much the work of the advisory committee. Conceptually, if you said that gold was, if you like, the fully comprehensive product, you would make sure that if the term 'gold' was to be used, it included a core set of product elements within the private health insurance product.

Senator DI NATALE: Which you have not nailed down yet.

Mr Cormack: It is a work in progress. Gold will mean gold—

Senator DI NATALE: You have not set criteria that each product will have to meet?

Mr Cormack: Exactly. That is right. That assists consumer choice and stimulates competition, and we believe that will be an important signal to the private health insurers to improve their product offering and greater transparency. That is the point of it.

Senator DI NATALE: Where do the junk policies fit into that?

Mr Cormack: We will be working through all of the different product types so that we can group them into higher order products, if you like, gold; those with lesser features are silver; and then bronze. There is not a common definition of junk policies, for example.

Senator DI NATALE: No, but this is the point of the work that you are doing. Let us be frank, some people are taking out policies not because they want the cover but because they do not want the taxation penalties and they want the benefits associated with the regulatory changes that have been made by government.

Mr Cormack: That is right.

Senator DI NATALE: There will be some policies that are useless. Will they be in the bronze category? Are you going to have a 'dud' category, the wooden spoon?

Mr Cormack: That is the work that the committee will be progressing and they will come back to government with advice about what to do with what you refer to as junk policies.

Senator DI NATALE: I think they are widely referred to as that. It is a fairly commonly used word.

Mr Cormack: They will come back with definitive advice on that. But the important point is to work through the common product descriptions of gold, silver and bronze. Then for those that do not fit into that category, there may be another set of policy options for government to consider in terms of what it does with those sorts of product offerings.

Senator DI NATALE: Has the department done any work on the notion of medical savings accounts? I think it was Dr Harmer from one of the stakeholder groups who called for that reform. Has the department done any work in that area that you are aware?

Mr Cormack: Within the consultations undertaken last year, there were some suggestions put to the department that was gathering a lot of the feedback about some alternative models to private health insurance and they were included in the mix of advice that was put forward earlier this year.

Senator DI NATALE: So, was advice provided to government from—

Mr Cormack: There are a number of players out there in the marketplace both within Australia and overseas, who have suggested that as an alternative. Certainly, there has been no government decision taken on—

Senator DI NATALE: Is the department doing any work on that specific proposal, that you are aware of?

Mr Cormack: We are not doing any further work on that. If we are asked some specific questions about it, we will obviously undertake some more detailed advice, but there is no work going on in that at the moment.

Senator DI NATALE: Perhaps I will just finish where I started. Has anyone done a cost-benefit analysis into the value we get for the $6.2 billion private health insurance rebate?

Mr Bowles: Not in that context at this stage. It is a government policy to have a rebate. I am sure it will get canvassed in the broader conversation with a ministerial group, but that ultimately becomes a decision of government.

Senator DI NATALE: I think I am done, thank you.

CHAIR: Senator Di Natale, did you have questions on dental services?

Senator DI NATALE: Absolutely, yes.

CHAIR: That will take us out—I beg your pardon, Senator Smith; did you have a brief question?

Senator SMITH: Just briefly, just on prostheses reform. It strikes me that this is actually quite a significant health reform—I think, Mr Cormack, you used the term 'wholesale reform'. We are talking about potential savings of up to $500 million over six years, 2,400 devices, but 400,000—what is the correct word; not 'patients', but—

Mr Bowles: Procedures.

Senator SMITH: Yes. This is phase 1; is that right, Secretary?

Mr Bowles: Yes.

Senator SMITH: So, when we are thinking about phase 2 and 3, are we looking at similar numbers of devices? Are we still looking in that 2,400—

Mr Bowles: It will not necessarily be devices next time. Devices could be part of it. There could be different reforms in the devices space. Through the PLAC, we will continue to do work in that. The stuff Mr Cormack was talking about is much past that; this is looking at private health insurance. Senator Di Natale talked about gold, silver, bronze—they also have impacts. There are tens of thousands of products out there; a number of which, in the tens of thousands, have no members, and they are still active and nothing happens with them. There are some really interesting dynamics in what Senator Di Natale classified as 'junk'.

Senator SMITH: The benefit of the prostheses reform; can we expect it to put downward pressure on insurance premiums?

Mr Bowles: You would expect that to be the case.

Senator SMITH: Direct benefits for consumers?

Mr Bowles: You would expect that to be the case.

Senator SMITH: In a lot of the early commentary around this particular reform measure, the figure of $800 million annual savings was thrown around. It might be important to get the department's response to that claim on the record. Clearly, there are sizeable savings—the minister has said that in her media release today, up to $500 million over six years—but $800 million annually is what—

Mr Bowles: We cannot possibly verify that number.

Senator SMITH: Despite the fact that it appeared in that Private Health Australia report?

Mr Stuart: The next effort that we will undertake with the PLAC will be to advise the government about a method of price setting which is much more transparent than we have now. While we have some information, and there is anecdotal information about particularly egregious examples of different pricing, we do not currently have a comprehensive dataset about prices locally in the public and private sectors and internationally. So the next piece of

advice is about how do we make this a lot more transparent. Prices should follow the market down, rather than putting a wet finger in the air about $800 million, or any other number.

Senator SMITH: Just finally, the Harper review was really the first place publicly that I can see where prostheses reform was canvassed, and canvassed quite aggressively. Starting in 2016, there was a much stronger campaign around prostheses reform, and we got to where we got to today with the minister's announcement. Was this on the department's radar prior to Harper?

I am curious to know why it has, in my perception, sat silently in the department? It seems such an important reform.

Mr Bowles: I am not quite sure how to answer that one. I think it has been an issue that has bubbled along quite often in conversations around the growth in private health insurance. Harper did give it a focus, and the minister did give it a forum, if you like. We were able to have that broad conversation, which has landed us where we are with that phase 1 of looking at the 7½ per cent and 10 per cent changes to prostheses. That is sort of where it is. I would not say it has necessarily been silent, but half are definitely—

Senator SMITH: But there are some strong vested interests—

Mr Bowles: There are significant vested interests in the private health insurance market. It goes from insurers, to hospitals, to device manufacturers, to public hospitals and to everything else that goes in-between, probably.

CHAIR: Senator Di Natale, before I call you, I am trying to manage some of the other senators that are coming and going from the committee. Do you have an idea of how long you have on dental surgery?

Senator DI NATALE: Fifteen or twenty minutes.

CHAIR: That will take us out of outcome 4.

Senator POLLEY: While we are sitting here, patiently waiting, can we agree to come back to the cancer register later, when he has finished in the other committee?

CHAIR: That is fine. That is outcome 2.4 that you are talking about?

Senator POLLEY: Yes.

CHAIR: Let's work to try to accommodate that.

Senator DI NATALE: Given that the government put legislation to the parliament on the closure of the Medicare-funded dental care scheme for children—the CDBS—can we now assume that the CDBS will continue to operate?

Mr Bowles: As you probably recall, the Commonwealth Child and Adult Public Dental Scheme—I just have to try and get my head around some of these names—was delayed. It was announced in the budget, to start in the new financial year. The legislation was not in place at that point; the minister extended it to start on 1 January 2017. The legislation still has to go to parliament and get its way through, obviously.

Senator DI NATALE: It has been to parliament; it was rejected. It was part of the omnibus legislation.

Mr Bowles: It was taken out of the omnibus legislation.

Senator DI NATALE: That is right, because it was not supported.

Mr Bowles: At that particular point in time—it does not mean that it will not come back in another form at some future point.

Senator DI NATALE: That is true of any piece of legislation, ever.

Mr Bowles: I can keep going, or you can run commentary on what I am saying, but it is due; we have extended the CDBS—the Child Dental Benefits Schedule—until 1 January.

Senator DI NATALE: It is extended until 1 January?

Mr Bowles: It is extended to 1 January—that is a well-known thing—as is the national partnership agreement. It is still the intent of government to legislate for a Commonwealth adult public dental scheme.

Senator DI NATALE: One of the criticisms of the scheme is that it has been under-utilised. Can you tell me how much has been spent, and how much is budgeted?

Mr Bowles: We can do that, but it is roughly under-utilised by about half.

Senator DI NATALE: The budget was about $2.7 billion or so, is that right?

Mr Cormack: I might ask Mr Maskell-Knight to give us the current take-up rates of the Child Dental Benefits Schedule.

Mr Maskell-Knight: Utilisation this year is sitting at around 33 per cent.

Senator DI NATALE: What is that in numbers?

Mr Maskell-Knight: It is a bit over a million children.

Senator DI NATALE: And the cost—the value of those services?

Mr Maskell-Knight: For the 2015 calendar year—because it operates on a calendar-year basis—the total benefits were $304 million.

Senator DI NATALE: $304 million—and what was the budget per calendar year?

Mr Maskell-Knight: The budget for that year was in excess of $600 million.

Senator DI NATALE: How do you arrive at a figure of only 33 per cent utilisation? You are saying that, if it were 100 per cent utilised, you would not have the budget to fund it?

Mr Maskell-Knight: It was never intended to. The original estimates were based on an assumed take-up of 80 per cent and on an average benefit per child. What has happened is that we are underachieving in terms of the utilisation rate and we are spending rather more per child.

Mr Cormack: It is a demand-driven program.

Senator DI NATALE: Yes. Let's come to that. We had this discussion at the previous estimates session. When I go to the department's own website, it is telling people that they will no longer be able to access the scheme after 1 January 2017.

Mr Bowles: That is correct.

Senator DI NATALE: So you are claiming that it is underutilised and yet you are providing information like that. We went around in circles at last estimates. You, on your own website, said that the scheme was closing from 1 July. That clearly did not happen.

Mr Bowles: That is correct.

Senator DI NATALE: And yet you continue to have that information, which proved to be false, and then you claimed that the scheme has been underutilised. Now you have

information on the website that says it will no longer be accessible from 1 January, when there is no support of the parliament to do that and it will, quite possibly—and I suspect in all likelihood—be again proven to be false, and then you will use, as part of your rationale for closing it, the fact that it is underutilised.

Mr Bowles: Let me just tick a couple of those boxes. It is not false when it was on the website at the points in time.

Senator DI NATALE: No, it was false.

Mr Bowles: No, it was not false when we were talking about it at that time.

Senator DI NATALE: I have the transcript here and I can read it to you.

Mr Bowles: Can I finish, Senator?

Senator DI NATALE: Sure.

Mr Bowles: I think we had an issue with the website at a point in time—yes—but the intent on 1 July, talking about when we said it was going to be 1 July, was for parliament to legislate to get that to happen. Yes, it did not happen and therefore it changed. It is now the intent to legislate to have this in place by 1 January 2017. If, in fact, that does not happen we will revise that again. In relation to just those two issues on the website, after the announcement of the adult public dental scheme, this has been underutilised since the start of the program in about 2014—

Senator DI NATALE: Because it was a new program and I think that was built into—

Mr Bowles: and it stayed underutilised and stayed at low take-up rates in each of the years subsequent—

Senator DI NATALE: Because the department did nothing to promote it and is now actually telling people it is not available.

CHAIR: Order! Let the secretary provide his answer and then we will move back to the question.

Mr Bowles: We can go around this buoy for a long time, but the reality is that the government decided, in the context of the 2016-17 budget, to fold the NPA, the national partnership agreement and the Child Dental Benefit Scheme into a new Commonwealth adult public dental scheme. That relied on legislation. There are issues with getting that legislation through—

Senator DI NATALE: It is called the parliament.

Mr Bowles: and we are still committed to a Child and Adult Public Dental Scheme because it is good policy in the dental space.

Senator DI NATALE: We spoke about this at the last Senate estimates. I am quite happy to table the transcript. I will read directly from a quote that you gave:

If it is not legislated—if, for some reason, that happens—we will provide the appropriate advice at that point in time.

It has not been legislated. Why aren't you providing advice that this is still available to people?

Mr Bowles: It is still available. It talks about 1 January 2017.

Senator DI NATALE: But you have no—

Mr Bowles: It is no longer available from 1 January 2017.

Senator DI NATALE: No, that is just false. That is false. Why do you continue to provide false information on the website? You cannot give any guarantee that it will be closed from 1 January. In fact, the parliament has just rejected it, and you continue to provide advice on the website to people who want to access it that they cannot access it. You may need a course of treatment. Sometimes these are people who need to engage in a course of treatment that might require two, three or four months. If you are going to see your dentist in a month's time they might say, 'We can't because the department website says this program will no longer exist from 1 January. We're not going to begin treatment in this period of time.' Why are you providing that information to people when it has been shown to be false, when it was provided previously, and in almost all likelihood it will be shown to be false again?

Mr Bowles: I cannot answer this any other way. It is the intent of the government to legislate. The minister has extended the current program until 1 January 2017, and that is where we are.

Senator DI NATALE: It is the intent of the government to have a plebiscite on marriage equality but you are not posting information to people about the nature of the plebiscite.

Mr Bowles: I cannot answer that.

Mr Cormack: Do you have an answer to that, Senator?

Senator DI NATALE: I do. I have questions about the fact sheets that are on the department website.

Mr Cormack: The website says the government envisages the initial agreement will be for five years. It also says it is anticipated that legislation establishing the new arrangements also close from 1 January 2017. So it is not a lie; it is qualified by—it expresses the government's intention and that it is subject to legislation.

Senator DI NATALE: If you are an ordinary punter and you go to the department and you read:

This means that the cost of dental services provided on or after 1 January 2017 will not be met by the government, and will need to be met by the patient.

Mr Cormack: Subject to the conditions that are on the website. If we were not doing that, we would be accused of placing consumers at risk of incurring bills when we know the government is going to be introducing a bill to establish the new scheme.

Senator DI NATALE: You are actively dissuading people from accessing the scheme that is currently open, and you cannot provide any information that would indicate to a person that this scheme will not be available from 1 January.

Mr Bowles: You are not going to get a different answer by saying the same thing. We had put on the website the information that is current government policy. If that current government policy changes, we will change the website.

Senator DI NATALE: Is this accurate:

Your child can use his or her entitlement up until the closure of the Child Dental Benefits Schedule from 1 January 2017.

Mr Bowles: That is correct.

Senator DI NATALE: You are saying that, definitively, is correct.

Mr Bowles: The child dental benefits scheme is open until it closes on—

Senator DI NATALE: That is a categorical statement.

Mr Bowles: I do not get the nature of the statement.

Senator DI NATALE: The statement that the department—

Mr Bowles: Your statement.

Senator DI NATALE: Again, I just want to get this on the record. You think it is accurate to say that your child can use his or her entitlement up until the closure of the child dental benefits scheme on 1 January 2017. No qualification.

Mr Bowles: You are reading one sentence out in the context of a whole web page there.

Senator DI NATALE: It is a 'frequently asked questions' page.

Mr Bowles: Exactly. But it is also in the context of the government moving to legislate the Commonwealth adult public dental scheme. It is easy when you take a sentence out of context, out of a broader conversation—

Senator DI NATALE: It is not out of context. I am reading it—

Mr Bowles: The minister has said this many times. We have talked about this many times. We had the same conversation, as you have suggested, in May. I have not changed my mind. I have changed the website to record 1 January instead of 1 July.

Senator DI NATALE: Let me read what the senator representing the minister said at the time, and this was because this information was provided stating that it would be closed on 1 July, which, again, proved to be false. Senator Nash said, specifically:

I did say that if parliament were to be dissolved then this would be assessed.

I said:

Assessed and changed?

She said:

Well, assuming that those things were no longer appropriate to have on a fact sheet then yes, of course.

Senator DI NATALE: Yet what we have is history repeating itself.

Mr Bowles: It is still the intent of the government—I do not know how many more times I can say this—to legislate the Commonwealth adult public dental scheme, and the minister has extended the current CDBS to the end of this year, to close on 1 January 2017.

Senator DI NATALE: It is the intent of the government to also increase the PBS co-payment. Are you providing information to patients about the increase in the co-payment?

Mr Bowles: I think we are now starting to get a whole lot of things out of context.

Senator DI NATALE: No, it is exactly the same point. I am asking a question. The government has legislation that has been knocked back by the parliament to increase the PBS co-payment. Are you providing information to patients to say that the co-payment will not increase?

Mr Bowles: Not specifically in that context—

Senator DI NATALE: Why aren't you doing that?

Mr Bowles: I cannot answer it to any more than that.

Senator DI NATALE: To use your logic, if the PBS co-payment were to go up and you were not to warn patients beforehand, you would not be doing your duty.

Mr Bowles: Again, there are a whole range of issues that need to be addressed over time. They are being addressed. In the context of this dental program, I cannot really say too much more.

Senator POLLEY: Didn't the Department of Human Services telephone line also advise for several months immediately after the 2014-15 budget that patients would be paying a $7 co-payment?

Mr Bowles: Again, I am not the Department of Human Services. I presume they may have—

Senator POLLEY: But you are not aware of it?

Mr Bowles: I do not run the Department of Human Services.

Senator DI NATALE: Are you issuing letters to patients to the effect that the scheme will be closed?

Mr Bowles: We do not—

Senator DI NATALE: Is another department?

Mr Bowles: The Department of Human Services would normally talk about this particular scheme. It is probably a question best asked of them.

Senator DI NATALE: I will have to wait until I speak to them to get a copy of those letters.

Senator XENOPHON: This goes to the issue of prostheses, the prostheses list and the controversy relating to the. I understand my colleague Senator Griff, and I think Senator Polley and others, have asked questions in respect of this. An assertion was made by the department that there is more market power in terms of public hospitals and private hospitals and that influences the price—it drives down the pricing that public hospitals can obtain. Is that right?

Mr Bowles: I do not think it is an assertion. I think I reflected on a personal experience, and working in public hospitals for 12 years.

Senator XENOPHON: Is it an assertion based on personal experience or is it an assertion?

Mr Bowles: I made a statement that one of the issues out there is market power. One of the other issues out there was the National Efficient Price. One of the other issues out there was that they went to a contract style that actually limited the number of procedures, and they got better buying power.

Senator XENOPHON: For instance, in terms of DRG code 103B, a hip replacement, it shows I think that there were 18,000 separations with a charge in the private hospital system compared with 11,000 in the public system. The cost to the public system was $6,341 compared with $10,656 in the private system. An orthopaedic surgeon who contacted Senator Griff's office said that that is not accurate.

Mr Bowles: Again, we are taking one piece of what I said and just applying it to one DRG. I look at the system as a whole—

Senator XENOPHON: I have lots more, but I have run out of time.

Mr Bowles: I am sure there are a lot of DRGs where that will be true. But there is also a National Efficient Price that puts overall price pressure in the public system. There is also a notion of contracting, which does not happen in the private sector, because the private sector is generally run hospital by hospital, and sometimes clinician by clinician. In the public sector a lot of the times they are going hospital-wide, area-health-service-wide, or in some cases state-wide in actually looking at their contract models. So it is a combination of a range of things that actually makes it different across the public and private sectors. I am just talking from my personal experience in the public sector, because I have actually seen that happen in that contracting way and how we actually look at the number of prostheses used. So, if there were 15 hips, you might actually bring it down to three or four.

Senator XENOPHON: I will put a number of questions on notice. You spoke earlier in answer to questions from Senator Polley in terms of leaks of information in terms of prostheses pricing. If those allegations are correct it could involve a breach of section 70 or 79 of the Crimes Act. Given the public interest issues here—that it would actually be counter to the public interest for any such lead to occur at such delicate negotiations—can the department advise whether the Federal Police have been asked to investigate this matter?

Mr Bowles: It is probably a question best asked of PM&C, because they manage that breach of cabinet confidentiality—

Senator XENOPHON: It is your view that it should go to the Federal Police for investigation?

Mr Bowles: Where I am at is that I have done an internal review trying to work out from the department's perspective if this was the case, because I have seen a counter-view put about that, as well, and I want to be in a situation where I have the full facts. I do not have the full facts yet. There were a couple of my staff at that meeting. I do not think there is a definitive statement that I have seen yet that would indicate it was just something like that. But, clearly, I have asked for that internal review. When it is finalised I will probably form a view about how we would go from there. In the broader sense, PM&C would do those sorts of things.

Senator XENOPHON: So you would have no idea whether it has been referred to the Federal Police?

Mr Bowles: No, I do not, personally.

Senator XENOPHON: Given the seriousness of the allegation—I just emphasise 'allegation'—made in *The Australian* newspaper that it is a matter that ought to be investigated by the Federal Police.

Mr Bowles: It is not up to me. It is a matter for PM&C, because they actually manage that process.

Senator XENOPHON: And presumably you, as secretary of the department, would make a recommendation to PM&C as to whether it ought to be investigated for a breach of the Crimes Act.

Mr Bowles: Not in the normal course of events. I am looking at mine—if it actually comes out through my process that someone says, 'Yes, this did happen,' I will talk to the

secretary of PM&C and ultimately he will make the decision and I will have a conversation with him about my view on that.

Senator XENOPHON: What is your view?

Mr Bowles: I have not formulated my view, because I have not got to the end of the internal review—

Senator XENOPHON: When will the end of the inquiry take place?

Mr Bowles: I think I said to Senator Polley, hopefully by the end of this month.

Senator XENOPHON: At that point you will make a decision as to whether it should be referred to PM&C?

Mr Bowles: No, I will make a decision about how I talk to the secretary of PM&C, who has the responsibility around cabinet type breaches.

Senator XENOPHON: And that talk with the secretary of PM&C may include your views as to whether it should go to the Federal Police?

Mr Bowles: It may.

Senator XENOPHON: Other than writing letters to the suppliers themselves offering that they volunteer data of their choosing, what research has the department done of prices on the prostheses list versus public systems in Australia?

Mr Cormack: As part of our private health insurance consultations, which commenced last year and continued and continued this year, the department undertook a concentrated body of work to look at the whole issue of prostheses and pricing. That was chaired by Professor Lloyd Sansom, who undertook a body of work from February through to April. Through the course of that work we had a look at international sources of information, we had a look at domestic sources of information and we also sought on a voluntary basis information from state and territory governments. We also interviewed a number of people who are involved in the industry, from the point of view of private health insurers, private hospitals and consumers. I have to say that it was very difficult to get definitive, verifiable sources of information, so a lot of this information was provided in a fairly unstructured way. But what Professor Sansom was able to deduce from extensive consultation was that there did seem to be a discrepancy or a difference between what some hospitals were paying for prostheses compared with what other hospitals were paying for prostheses, and that appeared to be related to whether or not they were covered by insurance. So the public hospitals were able to get their prostheses at a lower price than some private hospitals. It was really hard to nail solid sources of information, but on the balance of all the interviews undertaken and information that was collected that was the conclusion that was formed.

Senator XENOPHON: I will put a number of questions on notice. In regard to the committee process in relation to issues of perceived conflict of interest, dealing with lobbyists and the like, I will put a number of questions on notice as to what the protocols are. I suspect we may be dealing with these at the next estimates, but I will put on a number of detailed questions on notice with a background in them and hopefully I will not have to follow it up with supplementary questions.

CHAIR: That concludes outcome 4, and takes us to outcome 2. We will start with you, Senator Leyonhjelm. I believe you have some questions on program 2.4.

Senator LEYONHJELM: Mr Bowles, I am talking primarily about nicotine and nicotine replacement. I did have a question for the TGA, but I think I will rephrase it and give it to you folks anyway.

In the November 2015 Senate estimates, I asked the Department of Health about the status of the review of Electronic Nicotine Delivery Systems, or ENDS, and smokeless tobacco. I was told that the review would go out to broader consultation 'later this year'—that was 2015, presumably. I understand this broader consultation did not include what are known as vapers—users of e-cigarettes—or the general public. I am wondering why that was the case.

Dr Southern: The consultation process on that draft discussion paper was a targeted consultation, so it was undertaken with Commonwealth, state and territory government agencies, and public health experts and organisations. Ms Davis may be able to assist further in how that group was selected. This is a report for Commonwealth and state governments, to be considered through the AHMAC, the Australian Health Ministers' Advisory Committee, and the COAG health ministers council, and we are still tracking towards that at the moment.

Ms Davis: Yes, it was a deliberate decision to limit the consultation to experts who could provide a range of views to inform the development of policy options. The range of experts chosen was intended to reflect the diversity of views on this particular issue.

Senator LEYONHJELM: Are you satisfied that that diversity of views was captured without asking any users of e-cigarettes?

Ms Davis: In the event that the decision is made to pursue a particular policy option, as a possibility I understand that a broader consultation process may be considered as well.

Dr Southern: And we would have to undertake, I imagine, a regulation impact assessment as well that would involve public consultation.

Senator LEYONHJELM: All right. That sounds like the consultation you have after you have made a decision though. I am just wondering whether consultation before you make a decision might be helpful.

Dr Southern: I think that the paper that health ministers will ultimately consider would include a range of policy options, and it may be on that basis that we go forward to consult more widely.

Senator LEYONHJELM: All right. When will the review be finalised? And when and will the findings be made public?

Dr Southern: That will be a matter for COAG health ministers to consider when they look at the paper. I think it is tracking towards being considered by health ministers early next year.

Senator LEYONHJELM: Early next year; thank you. Minister Ley has recently announced the intention for Australia to use more assessments by 'competent, trustworthy overseas regulators,' and that 'the department and TGA will look to the likes of Great Britain and New Zealand and develop a regulatory framework—'

Mr Cormack: Excuse me, Senator, I think we might be in another outcome at the moment. That is the TGA.

CHAIR: Yes, I think Senator Leyonhjelm did say he would rephrase one of the questions he had for the TGA.

Mr Cormack: I am just not quite sure that we have got the TGA here at the moment.

Senator LEYONHJELM: You can tell me if it is a TGA issue after I have finished the question, and I will repeat it later if I have to.

CHAIR: And could you direct where that might come back?

Senator LEYONHJELM: Will the department—and I did include the TGA in this question—look to the likes of Great Britain and New Zealand and develop a regulatory framework to enable the sale of nicotine-containing cigarettes—e-cigarettes?

Mr Cormack: You have two blended issues there.

Senator LEYONHJELM: You can leave a TGA out of it, if you like. Will the department—

Mr Cormack: There is clearly a TGA element to it, if you are talking about devices and medicines. The other one is perhaps more related to the issue of tobacco control.

Senator LEYONHJELM: The issue is that the minister has announced a policy of greater us of assessments of comparable, trustworthy overseas regulators.

Mr Cormack: In the context of medicines and medical devices, which is a TGA issue. That is on later this evening.

CHAIR: We will leave that until then.

Senator LEYONHJELM: I will move on. New Zealand, Singapore and the UK are considering plain packaging, but they are planning to include cigars. Are you familiar with their reasoning, and why is their reasoning not applicable to Australia?

Ms Southern: I am aware of the UK arrangement from a conversation which I recall having with one of my counterparts in the UK. It was that the British plain packaging laws and regulations are part of a package around children's health. At the time their decision was taken in the context that they felt that cigars were less of an issue in relation to young people, and that is why they were was excluded. This is a recollection of a conversation I had some time ago. I am not aware of the reasoning that underpins the New Zealand decision.

Senator LEYONHJELM: Do you take regulatory approaches like that into account in Australia?

Ms Southern: Certainly we have discussions with our counterparts about different approaches. In the case of plain packaging Australia was out in front and we introduced it first, so in large part other jurisdictions are looking what arrangements we have put in place.

Senator LEYONHJELM: At the previous estimates I have discussed with your colleagues—I think they were different people—the department's view on the size and extent of the illicit tobacco market. There was considerable scepticism from your colleagues in relation to the KPMG measure of that market, based on scepticism about the methodology. I was part of an inquiry organised by the Joint Standing Committee on Law Enforcement, at which we had Australian Institute of Health and Welfare evidence in which they said they saw nothing wrong with KPMG's methodology. Have you changed your views? Do you have a different view on the size of the illicit tobacco market, or will you do your own research on that?

Ms Southern: We have the same view that we had then, that we do not think there is an official or reliable estimate of the size of the illicit tobacco market in Australia. My colleague Ms Davis and I were at that inquiry and heard the AIHW discussion there. I think there was a follow-up question on notice which they responded to, where they talked about the different methodologies that KPMG had used. I do not think we have changed our view of the fact that we do not believe there is a reliable estimate at the moment.

Senator LEYONHJELM: Do you intend to seek a reliable estimate?

Ms Southern: My understanding is that the Department of Immigration and Border Protection and the Australian Tax Office are looking at the moment that working towards developing more accurate models to understand the size of the market.

Senator LEYONHJELM: If it turns out that the KPMG measure—I accept that KPMG is measuring different things from the AIHW, but there is a very big difference between the two numbers—if their methodology or further investigation suggests that the KPMG method is producing a more reliable result, what implications to think that has for your department?

Ms Southern: Our concerns always lie with making sure that where tobacco products are available the health messaging and the plain packaging is part of the product that is being sold. With illicit tobacco we have two issues. One is where the product goes on to the market without those messages, and that would be of concern to us if there are substantial amounts entering the market that way. But at the end of the day the compliance and law enforcement issues around illicit tobacco lie with other agencies. We would continue to work with them on reducing the size of the illicit tobacco market. But the statistics themselves would not necessarily point to causation, I guess.

Senator LEYONHJELM: If the evidence suggests that the illicit tobacco market is as big as KPMG suggests, and, as you rightly point out, that illicit tobacco carries no health warnings whatsoever, to the extent that health warnings matter there are consumers of those products missing out on those health warnings, therefore, from a departmental view, you would presumably have no interest in doing anything to encourage the size of the illicit market to grow. Would that advice be provided to government in terms of its broader policy objectives?

Ms Southern: I think I am following the logic. Certainly we would not want an the illicit market to grow in any circumstances, whether it is products that come in and are counterfeit and do carry the warnings, or those that do not. If we thought that the market of products that were not plain packaged was growing, then obviously that has health concerns and we would be providing advice in relation to those. If there are products on the market which are not plain packaged or bear the correct health warnings, then there are compliance issues for us if they come to our attention under the plain packaging legislation anyway.

Ms Davis: The ACCC is responsible for the health warnings, so we would share a joint responsibility in that instance.

Senator LEYONHJELM: This is my final question about it. The ACCC has no control over it because it is outside the law. The obvious thing to do, from a policy point of view for the government would be to look at what is making it grow in terms of tax and things like that. Do you think the health department would say to the government, 'This market is growing. It is having implications for health warnings. The goose is being plucked too hard'?

Ms Southern: I think we are roaming into hypotheticals here. Our basic concern always would be fundamentally around the impact it would have on smoking prevalence and the impact on health. You would have a whole-of-government response to something like that occurring.

Proceedings suspended from 16:15 to 16:30

CHAIR: The committee will reconvene. We will get underway with Senator Watt.

Senator WATT: I have got a series of questions about the National Cancer Screening Register. I think Senator Di Natale very briefly touched on this this morning, but we did not get very far at that point. I do have some specific questions about the tender process. I am not sure if there are particular officials who we need to get involved here.

Mr Bowles: We should be okay.

Senator WATT: Okay, great. We had a full day hearing on this in Sydney and it was very frustrating that we did not have anyone at that hearing who could tell us anything about the tender evaluation process. I am hoping to get a few answers about that today. I am very conscious that this bill has passed through parliament, the tender has been issued and the contract has been issued, but we do still have some concerns about process.

In the department submission to the Senate inquiry that we held about the legislation behind this register, the department said that in developing the register a number of options were considered, including an approach to market. My understanding is that when a government is looking to set up something like this in some situations it might go to a limited tender, in some situations it might go to a prequalified tender and in some situations it might go to an open tender. In this case, a decision was made to go to open tender. Who decided to use an open tender process?

Dr Southern: The process for developing something like the register goes through a first and second pass process, which is ultimately a cabinet process. If it is a large ICT program, which this was clearly going to be, the process is that you do a first pass business case, which is considered, and then a second parts business case as it gets worked up. It tracks through a cabinet and budget process, effectively.

Senator WATT: So ultimately it was a cabinet decision to go down that path? Sorry, I'm not asking you about advice to cabinet. I am just—

Mr Bowles: Ultimately, the department does the work up and we provide options. It is more usual than not that we go to open tender for a whole range of these sorts of processes.

Senator WATT: I remember on the day this hearing I had some of the statistics, and I think for health—I cannot remember the exact time period this was over—about 50 per cent of the time the department had gone to open tender and 50 per cent to not open tender.

Mr Bowles: It would just depend on what we are talking about. Sometimes we will actually go to a select tender, meaning we will pick three, four or five—whatever it happens to be—off a panel arrangement and then we will do effectively what we would normally do in an open tender arrangement.

Senator WATT: Before getting to cabinet, was it the department's recommendation that open tender be used?

Dr Southern: That would be going into the nature of the advice that we provided the government. In working up the first pass business case, we developed up a number of options on how something like this might be taken forward.

Senator WATT: So the department's advice was simply to provide options. You might go open tender, you might go limited tender, you might go prequalified tender or there might be other categories, but cabinet's ultimate decision was to go open tender. It does not seem that that is secret, because that is what ended up happening.

Mr Bowles: Yes, it was the normal process. We put options and decisions are made. Again, it is not unusual for something like this, particularly with complex IT related projects.

Senator WATT: You might have just started answering this question, but why was the decision made to go open tender rather than prequalified or limited tender?

Mr Bowles: Again, the normal process would be that if we are looking at options in the marketplace for an IT related project, we would go to open tender. I cannot go to what cabinet might have thought and all those sorts of issues, but this is not unusual in government circles.

Senator WATT: It is a bit like what we were talking about this morning with the payment system. There is certainly a technical aspect to this register, but it is more than just that. It is not just about the provision of IT services; it is the management of a registry that includes patient information and all the rest of it.

Mr Bowles: We wanted to get the best option available. This has been something that has been done quite specifically state by state or not even that well in some cases. We are looking at a national system. The process that we would take was agreed to with the states and territories. This was something that was discussed with the state and territories. I know I had a conversation with my state and territory colleagues around how we would look at a national approach to this. From memory, I think I might have even written to them asking for their indicative support. They all came back with their indicative support for the approach that was being taken.

Senator WATT: The state governments did?

Mr Bowles: The CEOs did.

Senator WATT: The CEOs of the health departments?

Mr Bowles: The CEOs of the health services. My counterparts, if you like, in each of the state and territories.

Senator WATT: So they came back with their support to use an open tender?

Mr Bowles: No, they came back to support a national approach to this registry.

Senator WATT: Did the minister or her office tell you that they wanted to use an open tender?

Mr Bowles: Not to my knowledge.

Dr Southern: No, not that I know of.

Mr Bowles: It is not something that, in my experience in the public sector, has ever really come up in a ministerial or that sort of context, to be honest. I have been doing this for a little while across a few different departments. Ministers generally accept departments' views on

what is the best approach to market, which is what we are talking about in these cases, and the minister definitely did not talk to me about approaches in this context—and not to you either?

Dr Southern: No.

Senator WATT: Were you unhappy with the existing providers of these registers? My recollection from the hearing was that the Department of Human Services was already running the National Bowel Cancer Screening Register and then you had a fairly fragmented system in relation to cervical cancer. But the providers of those included NGOs and maybe even a couple of state governments—I cannot remember. There are a range of existing providers for these types of registers. Were you unhappy with those existing providers prior to beginning this process?

Mr Bowles: I do not think I would characterise too much about being unhappy, but it was a fragmented system. As I have said, we have had a conversation with states and territories, and they were keen on a national system. We were actually changing the way we screen. We are moving to HPV screening mechanism, which is one of the other things that really drove the change in approach.

Senator WATT: Was there anyone outside of your own department that you consulted about the decision to use an open tender? Any other departments?

Mr Bowles: I do not think so. I could not say off the top of my head, but it would not be normal that we would go outside the department and someone would tell us, 'No, you should do this or should do that.'

Senator WATT: I am just remembering what you told me earlier anyway was that the department did not really put up a preferred option; it put up a series of options from which cabinet chose to go down the open tender path.

Mr Bowles: Yes.

Senator WATT: Did you consult the Department of Human Services prior to deciding to go down an open tender path?

Dr Southern: Given the Department of Human Services runs the National Bowel Cancer Screening Register at the moment, in the context of working up the options, we certainly had discussions with them about how the current system operates and its capacity to take the increase in the size of the bowel cancer screening program. While with cervical cancer we are changing the nature of the test, with bowel cancer it is being expanded to operate every two years instead of every five years. We were looking at a substantial increase in the number of tests that were going to be undertaken and the number of invitations that had to be issued, et cetera. My recollection is that, in the lead-up to the first-pass business case, we certainly spoke to DHS in relation to their operation of the current screening register.

Senator WATT: Did you talk to them about their capacity to deliver this expanded service?

Dr Southern: I did not, no, but they were aware of the fact that there was this requirement that capacity had to increase because of the increase in numbers, and recognition that the current system, which was paper based and quite cumbersome, would not have been able to deliver that expansion, as far as I am aware.

Senator WATT: Their position was that, with the existing systems they had, the paper based systems, it would not be possible to use those systems to provide this wider register?

Dr Southern: Yes. You would have to have a new—

Mr Bowles: Yes. It would not be an efficient way, to look at any paper based systems.

Senator WATT: Was there any discussion with them about their ability to deliver the register provided a more technologically up-to-date mechanism was used?

Mr Bowles: My understanding is no, and we did not really go past discussing that once we got into looking at how we would approach the market. Again, we are looking at quite a fundamentally different approach, if you like, than what had been there in the past.

Senator WATT: One of the things I remember from the last hearing is that it seemed odd that we had an existing government department who had built-up expertise et cetera in providing one-half of this new register—admittedly with pretty obsolete systems—but that not only was the decision made to go to open tender and make them compete but, in the end, they did not even put in a tender. Was there any discussion between the two departments prior to their decision to not tender?

Mr Bowles: There would not have been, because there would have been a probity related issue, so we definitely would not have gone down that path.

Senator WATT: You said before, I think, that the minister and her office did not tell you to use an open tender. Was there any consultation with the minister or her office about that decision?

Mr Bowles: Not to my knowledge. The normal process is that, once we go to market, that is a closed process, for probity reasons, and the minister will be advised once we have got an outcome.

Senator WATT: Can you just remind me when tenders opened?

Dr Southern: The tenders opened on 10 August 2015.

Senator WATT: When did they close?

Dr Southern: They closed on 8 October 2015.

Senator WATT: You have said that there were no discussions, either before the opening of tenders or during that tender process, between the Department of Health and the Department of Human Services about Human Services's interest in tendering, even before the tender process started.

Dr Southern: Not about their interest in tendering, no.

Senator WATT: And there was no discussion at all with them about their ability to provide this you-beaut new system with updated technology?

Dr Southern: Not as part of the tendering process, no.

Senator WATT: Did it ever occur to your department that continuing to use an existing government based provider with that experience might prove to be the more efficient way to go rather than opening this up to the market?

Mr Bowles: We were talking about quite an antiquated system, using paper based technology technologies. The market does provide very good technologies for these sorts of things, and that is effectively where we were.

Senator WATT: But it would have been possible for Human Services to engage that technological capacity from the private sector that they did not have internally?

Mr Bowles: You will probably have to ask them.

Senator WATT: I certainly will.

Mr Bowles: I am sure they could do a whole lot of things.

Senator WATT: Yes.

Mr Bowles: But this was a policy position of ours and, with the change to the cervical screening and the bowel screening going from five years to two years, we were looking at a different model, I suppose.

Senator WATT: You mentioned earlier that, prior to cabinet making the decision, you provided a range of options from which it could choose. Did those options include a DHS-based solution?

Mr Bowles: I do not think we really should go to what is in a cabinet document.

Senator WATT: Okay. And you do not know why Human Services did not tender?

Mr Bowles: No.

Senator WATT: You have never gone back and asked?

Senator REYNOLDS: Can I just clarify that you never asked because it is a probity issue, as you said before?

Mr Bowles: When you get into tender arrangements you do not talk to anyone who potentially can—

Senator WATT: I am more asking that, once the tender had finished, once it was all over, no-one from Health has ever gone back and asked, 'Why didn't you do this?'

Mr Bowles: I didn't.

Dr Southern: No, I didn't.

Senator WATT: Is there anyone behind you who—

Mr Bowles: No, it if would have happened, it might have happened at a lower level in the organisation. But, at the end of the day, once the decisions are made, decisions are made.

Senator WATT: So tenders closed on 8 October 2015. Can you remind me when the contract was signed with Telstra?

Dr Southern: The contract was executed on 4 May.

Senator WATT: On 4 May 2016?

Dr Southern: That is correct, yes.

Senator WATT: Which was how many days before the election was called?

Mr Bowles: Five.

Senator WATT: Five days. But obviously, you had to be living under a rock to not know that the election was coming.

Mr Bowles: The government is the government until it is not.

Senator WATT: Yes.

CHAIR: We will stick to questions and answers.

Senator WATT: I think there was a question, but anyway—that period, it was roughly about, what, seven months between tenders closing and Telstra being awarded the contract?

Dr Southern: Yes.

Senator WATT: During those seven months, did your department consult—just remind me who conducted the tender evaluation. Was that done by Health or people within Health?

Dr Southern: It was done by people within Health.

Senator WATT: The panel was entirely Health officials?

Dr Southern: Yes.

Senator WATT: And did you—

Dr Southern: Sorry, yes—the tender evaluation committee and the project board were Health officials, but we had external probity, legal and procurement advisors. But they were providing advice, they were not part of the evaluation.

Senator WATT: I think, from memory, at the last hearing I asked on notice for the names of the people on that tender evaluation panel. Has that been provided?

Dr Southern: Yes, it has.

Senator WATT: Do you mind telling me who they were?

Mr Bowles: It is not something to put public servants' names into the public arena.

Senator WATT: But that has been answered, though, anyway, has it?

Dr Southern: Yes, it has been.

Mr Bowles: I would prefer to leave it in that sort of context.

Senator WATT: Sure. But did your department consult the finance department or any other department during that tender evaluation process?

Dr Southern: Not that I am aware of.

Senator WATT: Did you consult the minister or her office? Did you give her or her office any updates about how the tender evaluation was going?

Dr Southern: There were updates provided on the process, but not where the considerations were going.

Senator WATT: Did you ever update her as to who the tenderers were?

Dr Southern: No.

Senator WATT: Really?

Dr Southern: Yes.

Mr Bowles: That is a normal process.

Senator WATT: So the first that the minister or her office knew that, for instance, Telstra had put in a tender was when you advised her that they were the successful tenderer?

Mr Bowles: Once we had executed the contract, I think. Again, it is the normal process that we go through. It protects everybody.

Senator WATT: This was a $200 million contract, wasn't it, in the end?

Dr Southern: Correct.

Senator WATT: My recollection from the last hearing was that the decision to award that contract to Telstra was a departmental decision.

Dr Southern: Correct.

Senator WATT: When was that decision made?

Dr Southern: The decision—sorry, I have just lost that—

Mr Bowles: It was 3 May.

Dr Southern: Yes. The approval was on 3 May and the contract was executed on 4 May.

Senator WATT: On 4 May?

Dr Southern: Yes.

Senator WATT: And that decision was made by—who is the delegated officer?

Dr Southern: It was myself.

Senator WATT: And that was the recommendation of the tender evaluation panel?

Dr Southern: That is right; on the recommendation of the project board, who had been advised by the tender evaluation committee.

Senator WATT: But you are the person who signed it off?

Dr Southern: That is correct.

Senator WATT: Prior to that decision being made to give it to Telstra, was there consultation with the minister or her office?

Dr Southern: Not on the outcome of the tender, no.

Senator WATT: And you are saying that that is the usual practice, even for contracts of that magnitude—$220 million?

Mr Bowles: Yes.

Dr Southern: Where the authority was delegated to the department.

Mr Bowles: This happens in a broad range of projects well and truly above the value of this. The decision was made to do this, to go into the marketplace, and it is over to us to come up with the answer.

Senator WATT: What was the process for the tenderers? Ordinarily people come and give a presentation and that kind of thing. So Telstra, among others, put in a formal tender. Did Telstra come and do a presentation or anything like that as part of the process?

Dr Southern: Yes. I was not part of those presentations, but the short-listed tenderers came and gave presentations to the department. All were given equal amounts of time and the opportunity to present their proposals.

Senator WATT: Did you or anyone else within the department have any separate contact with Telstra—any meetings or phone calls with Telstra about this topic—during that tender evaluation process?

Dr Southern: No, except in the circumstances where the probity arrangements allowed for it.

Senator WATT: Dr Southern, did you say that you were on this project board?

Dr Southern: No. I was the delegate.

Senator WATT: Who ultimately signed?

Dr Southern: Yes.

Senator WATT: Are we able to find out—and I do not know if there is anyone here who was part of the project board—whether there was any contact from Telstra to them during that process?

Mr Bowles: The normal process would be that, once you have selected a tenderer—and they went down to two tenderers—there would be contact with both tenderers, trying to work out what the best options are. Ultimately, you get down to one and then there will be a contract negotiation process with the successful tenderer before you get to the execution of the contract. You just do not execute a contract based on what they—

Senator WATT: No.

Mr Bowles: There would be a lot of contact through that sort of chain. If you are asking whether there was contact outside of the tender process in relation to the tender, I would say no.

Dr Southern: There were quite lengthy parallel negotiations with the final short-list—the two final contenders. Following that process, when it came down to Telstra, there were the contract negotiations with Telstra.

Senator WATT: I take it Ms McGlynn had some involvement in this, having just joined the table.

Ms McGlynn: It was not me—as you see, I am acting in this position—but I am advised and I am aware that the probity arrangements under which this was carried out would require anyone who had any contact with Telstra about this tender process or any other business to declare that under the probity arrangements, and that would have been recorded. If, under those circumstances, there were any points of clarification about this tender process, that would only be about the process itself—and they too would have been recorded.

Senator WATT: You have told us that that is what would have happened? Do you know in this instance whether any contact with Telstra was disclosed in that fashion?

Ms McGlynn: I am not aware that there had been, but we can take that on notice.

Senator WATT: Who would that be disclosed to?

Ms McGlynn: It would be in the records under the probity process of the tender.

Senator WATT: Could you take that on notice?

Ms McGlynn: Sure.

Senator WATT: Thanks. What role did Mr Tim Kelsey have in Telstra's bid at the time.

Mr Bowles: Nothing.

Senator WATT: He was not involved at all?

Mr Bowles: No.

Senator WATT: My recollection is that he held a pretty senior role in Telstra Health at that time.

Mr Bowles: He did.

Senator WATT: And he was not part of any team that presented to the department and did not have contact with anyone in the department?

Mr Bowles: Telstra Health is a large, complex business. It is like a subsidiarity type company structure from Telstra itself. Telstra Health runs different businesses. That was their business model. They were looking at that. Mr Kelsey dealt with those sorts of issues.

Senator WATT: What sorts of issues did he deal with in Telstra at the time?

Mr Bowles: I cannot remember when he started. He started earlier this year or late last year. He was dealing with the broader issues of what health space Telstra could be in. You would probably have to talk to Telstra a little bit more about that. He had a broad role, not a specific role, and he was not involved in this register.

Senator WATT: What role does Mr Kelsey now have?

Mr Bowles: Mr Kelsey is now the CEO of the Australian Digital Health Agency.

Senator WATT: Which is an arm of your department?

Mr Bowles: It is a portfolio agency of mine, yes. Just so we are very clear: I was on the panel. The panel was chaired by the chair of the Australian Digital Health Agency. There was another board member on there and I think there was a representative from the states and territories on that panel. Mr Kelsey was selected through that process—totally independent to this. I had nothing to do with the register process in any way, shape or form right up to the delegate process. I did the negotiations with Mr Kelsey. I was on the panel. But ultimately the chair recommended to the minister and so on and so forth.

Senator WATT: And Mr Kelsey's current role? 'Digital health' could mean a lot of things. What sorts of things does he oversee now?

Mr Bowles: He has nothing to do with this register. He is oversighting the further rollout of the My Health Record and that broader digital health space.

Senator WATT: And some of those things we were talking about this morning about Medicare payment systems and those kinds of things?

Mr Bowles: No. It is quite specifically around the future of digital or ehealth—however we want to describe that. One of his key roles is the operation of My Health Record.

Senator WATT: So it did not cause you any concern about a potential conflict of interest for Mr Kelsey to be working in a senior role while this tender process was going on and then moving to a digital health role in the department? No conflict?

Mr Bowles: No.

Senator WATT: Was that raised with him?

Mr Bowles: The whole notion of him leaving Telstra and coming to work within was a negotiated process obviously. He had nothing to do with the register process. He said that to me, and I accept that. He has never actually raised one issue in relation to this with me and I have met with him a number of times.

Senator WATT: I do not know Mr Kelsey. I have no issue with him. You can just understand that there is a potential perception issue there.

Mr Bowles: I was on the panel. I selected him. I knew him while he was in Telstra and I knew him when he was in the UK. He applied for this job. He went through the process. He

was selected. It was totally independent to this process. To be frank, I did not know where this one was going at any stage during that process—as it should be. I get told after the delegate signs it. So I did not even know there was even that potential. In my conversations with Mr Kelsey, he was dealing with the broad Telstra health business empire—if you want to term it that way. However that works, I have no real clue. And that is the process.

Senator WATT: And, Ms McGlynn, you did not have any contact and the person you are acting for did not have any contact with Mr Kelsey through the process?

Dr Southern: No.

Senator WATT: I think you said earlier that the department made its decision to award Telstra the contract on 3 May.

Dr Southern: That is correct.

Senator WATT: And the contract was signed on 4 May.

Dr Southern: Correct.

Senator WATT: And five days later the election was called. So that makes it 9 May? I have forgotten the date the election was called.

Dr Southern: That is correct.

Senator REYNOLDS: Chair, I raise a quick point of order. I understand Senator Watt's intense interest in this, but I do distinctly remember most of these questions being asked by Senator Watt and his colleagues at the inquiry we had into this particular matter. He may want to ask the same questions over again, but I am not hearing any different answers from Mr Bowles.

Senator WATT: No. Senator Reynolds, what you will remember—

Senator REYNOLDS: Let me finish my point of order. I just want to note that we are obviously running significantly behind. If you had questions on notice that are repeating answers we have already received, that is fine. But there are other senators who have questions.

Senator WATT: I am annoyed that we are having to chew up time about this today as well. No offence, but the reason I am doing so is that the officials who attended that hearing on behalf of the Department of Health could not answer any questions about the tender evaluation process. That is why we are here today. If the correct people had attended, we would have dealt with it before the legislation was passed.

Senator REYNOLDS: I actually chaired that—

Senator POLLEY: Chair, on a point of order: Senator Reynolds has already spoken on the point of order.

Senator REYNOLDS: Senator Polley, with respect: I did not finish my point of order because I was interrupted.

Senator POLLEY: You chewed up so much time this morning. It's a bit rich!

CHAIR: Senator Reynolds can finish what she is saying—and I am happy to go through the statistics on how much time has been allocated to each party.

Senator REYNOLDS: Chair, Senator Polley has raised this point. How much time has the government had today.

Senator WATT: I actually do not need much longer.

CHAIR: Over half the time has been allocated to the Labor Party.

Senator POLLEY: Chair, that is not a point of order.

Senator WATT: How about we get on with it?

CHAIR: Yes, we should get on with it.

Mr Bowles: Senator Watt, in relation to your comment about the people attending the last meeting: Dr Southern was the delegate and she was overseas at the time. We had people there trying to assist the committee to the best of their ability without full knowledge of what Dr Southern has. So just to put that in context—and we can talk about this until the cows come home—we are very confident about the process for this register and I am very confident about the process for Mr Kelsey.

Senator WATT: I agree that the people who attended that day assisted to the best of their ability but there were obviously gaps in their knowledge—and most of the questions I am asking go to that process. I have just walked you through the time line. On 3 May the department made a decision to go to Telstra. On 4 May the contract is signed. On 9 May the election is called. Was the fact that there was a lot of discussion in the public domain about the likelihood of an election being called on 9 May a factor at all in the department signing that contract when it did?

Mr Bowles: No. Once a process starts we get it to a conclusion—and we got it to a conclusion at that particular point in time. Yes, there was an election and, yes, there was speculation about an election—but there was speculation about a lot of things at that particular point in time. We are public servants doing the work of the government of the day—and that is the process we had.

Senator WATT: The tender opened in August 2015, closed on 8 October 2015 and it took seven more months for the tender process to reach its conclusion. It was a big contract and you wanted to do it well. That seems like a fairly long time.

Mr Bowles: It was a big contract and a very complex set of circumstances. We whittled it down to two. We started the evaluation process for the two. We got down to one. We had to contract negotiate. With these things it can take time to get the best value for money for government—and that is what we do. And, yes, some of them take longer. I have been involved with some that go for well over 12 months—because it is important that you go through the probity process and the evaluation process in such a way that you end up delivering value for money for government.

Senator WATT: Did you or any of your senior officers have any exchanges with the minister or her office about the need to wrap this process up, about where this process was up to?

Mr Bowles: No.

Dr Southern: As I said earlier, we were advising on the progress of the process. But it was not in the context of 'We need to rush this' or anything.

Mr Bowles: There was no pressure put on me as the accountable officer to fast track this, speed it up or appoint anybody in particular. I make that point categorically.

Senator WATT: But you were updating the minister's office on the way through as to where the process was up to?

Mr Bowles: Yes, on the process—but not the people, who is in it, and all that sort of stuff.

Senator WATT: When was the last time you updated the minister's office before the decision was ultimately made?

Dr Southern: I would have to take that on notice.

Senator WATT: Okay. But there were no exchanges with the minister or her office in the lead-up to the decision about the need for a decision? Once that decision was made, was there any exchange with the minister or her office about the decision before the election actually being called?

Mr Bowles: We would have told the minister before the election. Once the contract is executed it is our responsibility to tell the minister we have just made a decision on this point.

Senator WATT: Once the election was called was there any discussion with the minister or her office?

Mr Bowles: No. We went into caretaker mode, quite seriously, on 9 May—or as soon as it was announced. In fact, I had a conversation with the minister and the then chief of staff quite specifically about caretaker mode and how we operate—as I do every time we go into caretaker mode. I am not telling people how to suck eggs at that particular point. As the secretary of the Department of Health, I am deliberately saying: 'This is how we're going to operate with you in that context. You can't ask me this. You can ask me that. The business of government continues but I'm not giving you policy advice on anything.' I had no conversations with the minister in the entirety of the election.

Senator WATT: When was the minister advised about the decision?

Dr Southern: We sent a submission to the minister's office on 5 May—the day after the contract was executed.

Senator WATT: Was that submission noted or signed by the minister prior to the election being called?

Dr Southern: It was returned to us as a submission for no further action when the election was called. There is a period of tidy-up implemented.

Senator WATT: It would simply have been for noting anyway if the decision had been made.

Mr Bowles: Yes, that is right.

Senator WATT: So a submission to note that a contract had been awarded was sent up to the minister's office on 5 May. It did not get signed off or whatever before the election. Am I right that there was a draft press release or draft announcement attached to that submission?

Dr Southern: I cannot remember if there was actually a draft attached to it. But in the submission we canvassed the idea that the minister may consider making an announcement.

Senator WATT: My recollection is that the department announced the issuing of the contract, as opposed to the minister.

Mr Bowles: It then goes to AusTender. From memory, I do not think we actually announced it.

Dr Southern: We did.

Mr Bowles: But that was post AusTender.

Dr Southern: Yes.

Mr Bowles: My understanding of the order is that we put the contract details on AusTender. The media then raised an issue with us and we put out a media release saying something happened.

Senator WATT: I will come to that. If it was always going to be the department that would make that announcement—and maybe I am wrong there—why?

Mr Bowles: If we were not in an election period, the minister would probably have made the announcement. We were in an election period. The department made the decision and it went on AusTender—and people sit and trawl through that stuff every day. So there was media interest and the department responded to that media interest—I cannot remember exactly what it was.

Senator WATT: Did the minister's office tell you that they did not want that contract announced?

Mr Bowles: No.

Dr Southern: No.

Senator WATT: So the submission went up with an attached press release or something like that. It did not get dealt with. There was no discussion at all with the department about an announcement.

Mr Bowles: Once decisions are made, it is an automatic process for AusTender to notify. We had been in the market for a period of time. The EOIs effectively go out on AusTender. There is a period of time and then AusTender put it up as an outcome—and you will get the contract outcome.

Senator WATT: You have referred to the media interest that occurred. I think that was about 26 May.

Mr Bowles: Yes.

Senator WATT: I think the report essentially said that Telstra had been issued the contract.

Dr Southern: Yes.

Senator WATT: And that report actually said that the minister was due to announce the contract during the campaign, sort of as an election announcement. Were you aware that the minister planned to announce the contract during the campaign?

Mr Bowles: I was not personally. I cannot even remember that being said, to be honest.

Senator WATT: I might be wrong there, but I thought it did.

Mr Bowles: Not in ours.

Dr Southern: It is not in our media release.

Mr Bowles: The minister's office may have responded.

Senator WATT: Not your media release. I am talking about the press reporting.

Senator McGrath: The media may have said something or implied something. You know what the media are like. They are very accurate!

Senator WATT: Very accurate!

Senator McGrath: Yes, and very reliable!

Senator WATT: They were very reliable that the minister was intending to announce the contract during the campaign?

Senator McGrath: I was speaking tongue in cheek.

Mr Bowles: That could have been the minister's office. I do not know. I have no recollection of that. I first became aware of the media interest on 26 May. A statement was put out by our spokesperson that basically went through the procedural nature of it. Yes, if there are then some other linkages in the story—because journalists do have a habit of trying to triangulate or whatever they might do to get an edge on the story—that is probably what happened. I do not know. To be honest, I have never followed it up on that side of it. We had to respond to a piece of media interest that was inaccurate. We did and we put that out there. I cannot even remember what we said at the time. I think we just factually said what we were doing.

Senator WATT: Did you speak to the minister or her office about that report?

Mr Bowles: No, I did not.

Senator WATT: So the report was brought to your attention and you independently went out and made the announcement?

Mr Bowles: Yes. I will make it very clear: from the day the election was called until the date the outcome was known I never spoke to the minister. I can talk to the minister but I never did. And she never talked to me about any of these sorts of issues—or any issues.

Senator WATT: Why did Telstra get this contract?

Mr Bowles: They were the successful tenderer?

Senator WATT: But why?

Mr Bowles: Because they were the successful tenderer.

Senator WATT: But what made them successful?

Mr Bowles: They went through the evaluation process and they were very strong in the evaluation process.

Senator WATT: This was one of the questions we could not get answered at the hearing the other day. In the end, why was it that Telstra was the successful tenderer?

Dr Southern: We took their proposal and analysed it against the selection criteria. Ultimately, they came out as the best value for money proposal against the criteria.

Senator WATT: I remember asking—and it being taken on notice—to see the tender evaluation documents or some sort of summary to explain why it was Telstra and not the others. Has that been provided?

Dr Southern: In our responses to the questions on notice, we had taken one on notice in relation to VCS against a couple of the criteria, which we provided a response to. But I do not recall that we had a question on notice about the full evaluation.

Senator WATT: If you did not, could you take that on notice today.

Mr Bowles: We will take on notice what we can provide you—understanding commercial in confidence issues and all the things that go with that.

Senator WATT: Sure. Where we were left at the end of that one-day hearing was that it was quite confusing as to why Telstra was selected given that there were a number of other tenderers, including existing providers. VCS is the obvious example but there were other non-government providers, NGOs, who tendered. The evidence we took on the day was that they clearly had the capacity and the experience; they had systems in place to deliver this register. Without telling us their tender price, it sounds like it was pretty close to what Telstra is going to be paid to do this. So you have an existing provider, with years of experience and reputation in the field, tendering for effectively the same price versus Telstra, with no experience in this field at all. Admittedly, they have experience in technology et cetera—

Mr Bowles: Yes, very deep experience in technology.

Senator WATT: but they have never run a cancer register. I am still curious as to how that kind of an organisation could get the tender over existing providers who are doing it at the same price.

Mr Bowles: We have quite rigorous evaluation criteria and processes that we go through. We would have gone through all the normal processes around who was best value for money. That takes into account not only money; you can be more expensive and still be better value for money because your technical capability is better. It is probably wrong to conclude that Telstra has no experience in registers per se. They have not run the cervical and bowel screening register, that is absolutely true, but they do have very, very deep experience with technology solutions in a similar vein. All of that gets played out through the evaluation process that, as we have provided evidence on, is evaluated by people in the department, independent of anything else that is going on out there. Again, after whittling down to two and then to one, the outcome was Telstra Health was the most appropriate under the value-for-money criteria.

Senator WATT: Did any lobbyists on behalf of Telstra have any contact with the department?

Mr Bowles: Definitely no lobbyists to me.

Senator WATT: I do not even know if they have lobbyists. Do you remain confident about Telstra's ability to deliver this register on time?

Mr Bowles: I do, yes. We have to be careful: it is not Telstra; it is Telstra Health.

Senator WATT: It was pretty concerning. Some of the evidence that we got that day, particularly from VCS, sounded like there had been multiple approaches from Telstra for information and know-how. Allegedly, Telstra were requiring you to produce this information, and we were left with a feeling that Telstra maybe did not quite have the capacity that the department had originally thought.

Mr Bowles: When you lose something, you do not want to get into those sorts of debates. We are not going to get into those debates. I do not find it unusual for a successful tenderer to talk to an unsuccessful tenderer. I have been involved in a number of things where people have lost contracts, and there is a formal process of handover arrangements that, in some

cases, can go for months as they transition from one to the other. It is not unusual for that to happen.

Senator WATT: Since we took that evidence, have you looked into those matters and the requests that were been made by Telstra for information to satisfy yourselves that they know what they are doing?

Mr Bowles: Again, if I go back to what I just said: it is not unusual for a successful company to talk to one who, even in this case, only had one or a partial part of this business. It is not unusual for them to talk. We remain confident, based on the outcome of quite a rigorous process, that Telstra Health can do the job.

Senator WATT: Thank you. That has been very helpful. I appreciate the amount of time that has been extended to me.

Senator REYNOLDS: Senator Watt indicated that he was not satisfied with your officials at the cancer screening inquiry. I chaired that inquiry, and I want to put on the record that I was very satisfied with your officials. There were a few questions they could not answer, but they provided the answers on notice. I heard nothing from your answer that contradicted your officials in any way. I just want to put on the record that, chairing that committee, I did not share Senator Watt's opinion.

Mr Bowles: Thank you.

Senator REYNOLDS: I heard Senator Leyonhjelm asking about e-cigarettes and the consultation paper. I have got a couple of follow-up questions on that issue. Could you tell the committee the health cost to Australians in terms of their own physical health and also the financial cost for tobacco-related illnesses. Do you have those figures available?

Dr Southern: A figure that we have referred to previously, a bit over $30 billion, was an estimate of both the immediate health costs and the secondary costs to productivity—so impacts on the economy. That was an estimate that was made about 10 years ago now. We do not have a more recent estimate. But even back then it was in the order of $30 billion.

Senator REYNOLDS: So you would expect that it would at least have risen through inflation but then adjusted for the reduction in smoking rates?

Dr Southern: Yes.

Mr Bowles: A lot of these things have a social and economic benefit.

Senator REYNOLDS: Even if it has flatlined since then, you are still talking, at a minimum, of a large social and economic impact on smoking.

Dr Southern: Yes.

Mr Bowles: There is a possibility that as we have improved dramatically over the 10 years that we would be improving some of those figures as well. If we did not, that $31 billion would probably be $51 billion by now because it does not take much to escalate costs, particularly in tobacco, with risks around cardiovascular disease and all the other things that go with smoking.

Dr Southern: In relation to those sorts of statistics, there is a long lag time as well for people to—

Senator REYNOLDS: And you cannot possibly capture all aspects, so it will be a general guess.

Mr Bowles: Yes. Someone who quit smoking 40 years ago can still get lung cancer and whole lot of things. There is a whole range of really tricky things in this one.

Senator REYNOLDS: Over the course of that 40 years, they might have been not as sick as they would have been.

Mr Bowles: Yes.

Senator REYNOLDS: I was listening to the answers to Senator Leyonhjelm's questions. He was asking about the consultation process for the draft discussion paper, which I understood from your answers is going to COAG later this year. Is that right?

Dr Southern: To COAG health ministers probably early next year.

Senator REYNOLDS: I was puzzled about the comment that there was a deliberate decision to limit consultation to experts who could provide a range of views on the development of this policy. Given the importance of this issue, I was just wondering if you could explain further exactly who you did consult. What was the range of consultations that occurred?

Ms Davis: We can certainly take on notice to provide a list of the experts consulted.

Senator REYNOLDS: Are you able to give me a rough idea of who was consulted? I would appreciate the full list, but was it state health departments and anti-smoking organisations?

Ms Davis: Certainly all the state health departments were consulted, and a range of experts were also consulted in that process.

Senator REYNOLDS: We have asked these questions before at estimates. I think my summary of the responses we have had in the past has been that they have been characterised by great reluctance on behalf of health departments and also the AMA and other organisations to really look seriously at e-cigarettes. It is my impression that there have been ways of stopping the discussion or slowing it down. You probably would not agree with my characterisation. How would you characterise the department's attitude to e-cigarettes?

Dr Southern: I think we would characterise it as taking a very precautionary approach to e-cigarettes. When it comes to the evidence around whether or not they are something that will assist people in quitting smoking or stop people taking up smoking cigarettes or what the broader public health implications are of secondary smoking of e-cigarettes, the jury is still out on the benefits and the downsides.

Senator REYNOLDS: When you say that the jury is still out on the evidence, are you talking about the Australian jury or are you talking about overseas as well?

Dr Southern: I am talking about the range of evidence that is available to us on e-cigarettes.

Senator REYNOLDS: So this review you said previously was restricted in terms of who was consulted. Can you be specific: did you look at overseas experiences, the most recent reports and what was your conclusion?

Ms Davis: Yes, I can confirm that part of the role of the University of Sydney who undertook the research for us was to review international experiences with e-cigarettes, and we continue to monitor international developments—at the next Conference of the Parties to the WHO Framework Convention on Tobacco Control that is happening in November in Delhi, the issue of e-cigarettes will be discussed and a paper has been released to inform that discussion by the WHO. As Dr Southern has indicated, that document does canvass the evidence base for the efficacy and safety of e-cigarettes, particularly in the long term, its potential or otherwise for cessation, its impact on bystanders, the toxicity and the range of toxicities that can exist, the harmful chemicals in e-cigarettes and all those kinds of issues. It is an example of the fact that the evidence base is very much developing and the evidence is out.

Senator REYNOLDS: So, in terms of the input, you had the University of Sydney do one report as a literature review, for example, of international evidence. So was it just that one review? You just contracted one person to do it?

Ms Davis: As part of the international discussion paper, the University of Sydney was the contracted service provider; however, I am aware that the NHMRC is doing work in this space. They issued a statement in March 2015 that recommends that:

… health authorities act to minimise harm until evidence of safety, quality and efficacy can be produced.

I understand that the research that they are undertaking at the moment will inform a review of that recommendation which we expect to be finalised in 2017.

Senator REYNOLDS: So it seems like there is a bit of disjointedness here. So when did the University of Sydney report?

Ms Davis: Their report was finalised in September, but it—

Senator REYNOLDS: Of this year?

Ms Davis: This year, yes, but that is part of the national discussion paper that was procured in order to develop options that will be put to government later in 2017.

Senator REYNOLDS: So the options are going to be put to government before the NHMRC's review is completed?

Dr Southern: It is happening in parallel, so what we are anticipating is that this paper will be ready for COAG health ministers to consider in early 2017. I understand the NHMRC is expecting to finalise its recommendations or its further guidance in early 2017 as well, so it is likely those two things will come together.

Senator REYNOLDS: So you have got the draft paper that has been informed by the University of Sydney study, which has already been circulated amongst the COAG members?

Dr Southern: Amongst the states and territories, yes.

Senator REYNOLDS: So then you have got the NHMRC report who will report later next year. Will the discussion paper be updated to take into account NHMRC findings?

Dr Southern: The advice I have—and we can confirm that with the NHMRC—is that they are expecting to finalise that piece of work early in 2017, so I think we have got two things that are coming together at about the same time.

Senator REYNOLDS: So then the discussion paper will be updated for any findings. If they say that we have to be more cautious or the world experience now in the last 12 months has moved on, then the discussion paper will be updated.

Dr Southern: It may be a case that the discussion papers are updated but, more likely, that we will have two pieces of information to come together.

Senator REYNOLDS: The reason I ask is that, after doing a bit of research myself, since the time that that uni of Sydney report was completed, there has been a number of major studies done overseas that I have, I think, progressed the case much further. For example, in April this year, UK's Royal College of Physicians concluded that it was in the public health interest to promote the use of e-cigarettes to help people come off smoking. Public Health England, who I believe are your counterparts, in August last year said in their third review on e-cigarettes—it is not their first but their third review of e-cigarettes—that there was no evidence that e-cigarettes undermined a long-term decline. It does not encourage smoking rates in young people or older people. Cancer Research UK conclusively said just recently, a couple of months ago, that e-cigarettes were much safer than smoking cigarettes. If you have a look at research in the UK, in the EU or in the United States, which are far ahead in a policy sense and are not just relying on one university, it seems quite overwhelming that all of them are trending towards saying that this is much safer and that it is a great way to get people, who cannot through any other means, off smoking cigarettes. I understand that Canada and New Zealand are now going down that path. All of those jurisdictions now seem to be focusing on regulation and safety considerations rather than going through discussions of whether it is actually better than smoking cigarettes.

Ms Davis: We are certainly aware of those studies, and they are something that will inform our development of Australia's position as it moves forward. But I hasten to add that there is no consensus on the issue of relative risk of e-cigarettes. I think there is agreement that they are safer, at least in the short term—or likely to be safer—than tobacco products. But, for example, *The Lancet*, *The BMJ*, the WHO and the US Centers for Disease Control and Prevention, as well as the European Commission, have questioned the correctness of the UK modelling and, in particular, their ability to nominate a percentage figure for the level of relative safety of e-cigarettes and—

Senator REYNOLDS: Are the ones you have just quoted recent? Are they this year?

Ms Davis: Yes. They post, date and comment specifically on some of the commentary that you just mentioned, and—

Senator REYNOLDS: Obviously, some of the ones that I have talked about and some of the ones you have talked about would have been post the University of Sydney report that has gone into the discussion paper. Have all of those issues been canvassed in the discussion paper?

Dr Southern: I think Ms Davis said that the report we received last month, in September, has been able to take into consideration the sorts of reports that you have just spoken about and that Ms Davis has spoken about.

Senator REYNOLDS: It does canvass both sides of the discussion right up to current times?

Ms Davis: Yes. I will say that part of the reason that we are taking a cautious approach is that the evidence base is very fluid. For example, this month the WHO's report, which will be discussed at the conference of the parties that I mentioned earlier, stated that 'no specific figure about how much "safer" the use of these products is compared to smoking can be given any scientific credibility at this time' and also indicates that e-cigarettes are not a harmless product. The levels of toxicants in e-cigarettes can vary enormously. The long-term use of e-cigarettes can be 'expected to increase the risk of chronic obstructive pulmonary disease, lung cancer, and possibly cardiovascular disease as well as some other diseases also associated with smoking', although the 'magnitude of these risks is likely to be smaller'—as you mentioned—than for tobacco use. Current evidence does not allow firm conclusions to be drawn as to whether e-cigarettes 'may help most smokers to quit or prevent them from doing so'. There is also the extent of the risk posed to bystanders by e-cigarette emissions and whether e-cigarettes may initiate youth in nicotine use and smoking. It is very much a fluid evidence base at the moment.

Senator REYNOLDS: Thank you, I appreciate that. Are you able to provide to the committee that University of New South Wales report that has gone out to COAG, the report that you commissioned and, presumably, that you paid for. If not, can you provide an extract of that report that actually shows—people commenting on this are concerned about it for very genuine reasons. We are operating a bit in the dark. We cannot really understand the position you have outlined. Is it possible to provide either that University of New South Wales report or at least the executive summary of the arguments on both sides? Please take that on notice.

Dr Southern: We can certainly take that on notice and we will do so. The WHO report that Ms Davis was quoting from is publicly available. That is probably an easily available source that brings together the state of the research at the moment.

Senator REYNOLDS: May we have both? If the taxpayers paid for the University of New South Wales report, unless there is something in there—

Dr Southern: We can take that on notice.

Senator REYNOLDS: It would be good to inform the public that bit further. I was very remiss, Professor Murphy, do you have an opinion on the health benefits of e-cigarettes versus normal cigarettes?

Prof. Murphy: My opinion would concur with the opinions you have heard today. It is an area where there is not a clear answer. Further work needs to be done and I think there are definitely risks. As was described before, there is a confusion of evidence at the moment. There is not a clear picture emerging. Therefore, I think a cautious approach is warranted.

Senator REYNOLDS: Thank you very much.

Mr Bowles: The comments that I get in the international space is no-one is really sure in some cases what goes into these particular devices. It is not only, unfortunately, nicotine. In some cases it is even worse potions, if you like. There is a whole range of issues that do keep coming up in this space.

Senator REYNOLDS: Mr Bowles, I understand and I share your caution. However, is that any different to what goes into traditional cigarettes?

Mr Bowles: Possibly not.

Senator REYNOLDS: I think the evidence internationally is that what goes into cigarettes that you actually smoke and burn is far more toxic than nicotine itself. It is a matter of standards, rather than—

Mr Bowles: I worry about the other things that people mix. There are a lot of funny things that people mix.

Senator POLLEY: We are now going to jump over to the issue around ice. Could you please remind us when the National Ice Action Strategy was agreed? Was the funding for implementing a National Ice Action Strategy for the year over the forward estimates?

Mr Bowles: I will ask Dr Southern to answer.

Dr Southern: The announcement around the funding was made on 6 December 2015. The announcement included additional health portfolio investment of $298.2 billion over four years from the beginning of July 2016.

Senator POLLEY: That is over the forward estimates, that $300 million.

Dr Southern: That is correct.

Senator POLLEY: When was the funding formula distributed? The $300 million—I have rounded it off—package to tackle ice, can you tell me when and what it is?

Dr Southern: There are several components to the strategy that are covered by that $298.2 million. The most substantial part of it is $241.5 million for primary health networks to commission further drug and alcohol services and then funding of about $19.2 million for local drug action teams. Then there is funding for a Centre for Clinical Excellence for Emerging Drugs of Concern, which is currently being pursued. Then there is some funding for clinical research and improving data sources on emerging trends.

Senator POLLEY: Can you tell me what consultation was undertaken, please.

Dr Southern: The consultation around the Ice Action Strategy was undertaken by the Ice Taskforce, which was a task force led by Ken Lay and was run out of the Prime Minister's department.

Senator POLLEY: How were the Joint Committee on Law Enforcement's findings addressed by the formula?

Dr Southern: Sorry. Which formula are you talking about?

Senator POLLEY: For the prevention of the use of ice. When you developed the formula for distribution of this money, were the concerns raised by the law enforcement committee's findings taken into consideration?

Dr Southern: I believe so but I am just a bit puzzled about the use of the term 'formula'.

Senator POLLEY: I am a bit confused, too.

Dr Southern: Are you talking about the way that the money is distributed between the PHNs for the alcohol and other drug services or the way that the package was put together? I am not quite sure.

Senator POLLEY: If you could perhaps walk us through how the package was put together and then how it has been distributed. You must have used some sort of formula to decide where the money was going and how it needs to be spent. I am sorry; this is all new territory for me, too.

Dr Southern: That is fine. The Ice Action Strategy, or the report that came from the Ice Taskforce basically had five key priority areas. They were family and communities, prevention and treatment, the workforce, law enforcement and research and data. So there were five priorities identified by the task force. The response to the task force was, as I said, announced by government on 6 December. And I think, on either the same day or the previous day, the broader national response was discussed at COAG. So the response is also one that the states and territories are contributing to. As part of the process of developing what the package would look like and how the government would respond to the recommendations of the report under those five priority areas, then it was a discussion about: if we are to increase alcohol and other drug services to deal with ice, what would be the quantum of that? So the package was then developed taking into account the particular recommendations of the Ice Taskforce and what was necessary.

Senator POLLEY: What consideration was given around prevention of the use? Obviously, there is a lot in the media. It has been raised many times in our chamber—

Senator Bilyk: In our state.

Senator POLLEY: Yes—particularly in my home state. There are real epidemics of clusters of high usage which are destroying the community. How much consideration was given to the preventions?

Dr Southern: It was one of the five priority areas in the recommendations from the Ice Taskforce. Some of the measures that I have described to you are specifically about drug prevention. So the local drug action teams, for example, are about delivering locally based in tailored alcohol and other drug prevention and education activities. The work on clinical research into treatment options and the data sources really all go to better informing ourselves about what works and what does not work. There was $24.9 million to support communities. That is partly the local drug action teams but also prevention and education activities. Perhaps my colleague Ms McGlynn could actually talk a little bit more about those educational activities which are underway.

Senator POLLEY: That would be good, but if you could also include how much of this money is actually going to reach the frontline in dealing on a day-to-day basis with this issue.

Dr Southern: The $241.5 million, which is the money for drug and alcohol treatment services, is very definitely for frontline services.

Senator POLLEY: So the majority of it, you are saying, will go to the front line?

Dr Southern: Absolutely.

Senator Nash: Just on the local drug action teams—this was really important. Many of the communities I visited were really keen to be involved in trying to deal with this locally and that is why we specifically put the Community Drug Action Team funding in place. That was really important.

Senator POLLEY: Can you confirm that funds have been distributed on a per capita basis?

Dr Southern: The $241 million for drug and alcohol treatment services is being delivered through Primary Health Networks. The formula for distribution between the individual PHNs is based on population and need.

Ms McGlynn: There was quite a detailed funding formula which was proposed and developed. Some modelling was done around that to make sure that the distribution of funds was done as fairly as possible. That was taken on population and also weightings for Indigeneity, rural and remote and socioeconomic disadvantage. It was really important, we felt, to get it right—to make sure that funds went where they were supposed to go. We checked that up with a number of advisers in those Indigenous and other areas to see that we got it right. We tried a number of different models to do that. The distribution has gone out under those terms.

Senator POLLEY: Can you outline for us whether you are reasonably confident—I know you cannot guarantee anything—that there will be increased money at the front line in regional communities?

Ms McGlynn: We are confident. The reason I can say we are confident is that not only have we looked at the funding formula and really thought about things like disadvantage and the number of Indigenous people in communities, but we have also been monitoring the expenditure of those funds and we have some guidelines around those funds to make sure that they are providing real services to people. They will be monitored, and we will report on those. There is a range of services which we know are evidence based for the use of that money. It is not that that money can be spent on just anything; we really look at the evidence and what the evidence says. Each of the Primary Health Networks has developed an activity work plan which needs to be approved by the department, and that is done in consultation with their local community on the basis of the drugs of concern in that area and what might be around. For those reasons, I think we can be pretty confident that not only will there be more services—because that is what the money is there for—but also that those services will be targeted at the right things and informed by the local community and the evidence.

Senator POLLEY: I want to be really clear about this: you have not based it on a needs basis for the communities but you are reassuring us that, if there is more need, say, in Smithton in north-west Tasmania, which has a higher proportion of users of ice, they will get more money than the chair's home town of Hobart?

Ms McGlynn: Thank you for reminding me about that. The first part of this process before the activity work plans are submitted is for the PHNs to develop a needs assessment. That is done on the basis of the data they have for their demographics and population, of where other services are located and other related services that might exist in their area. The needs assessment is followed by an activity work plan based on the guidelines and the evidence and then the PHNs come back with a plan that is signed off which demonstrates that they are responding to the needs of those communities and the evidence.

Senator POLLEY: Can you provide very specific details of the amount of money that has already been allocated and delivered?

Ms McGlynn: To the PHNs?

Senator POLLEY: Yes, so this money gets to the front line.

Ms McGlynn: That information exists. I believe it is on our website, but we can certainly provide that to the committee.

Senator POLLEY: What is the percentage of that money, would you say, that has already made it to the front line?

Ms McGlynn: The funding will flow differently, depending on the readiness of the primary health networks to roll that funding out. As you would appreciate, there is a need to commission services and to work within the community to do that. Some communities are more ready than others, and some have providers that are ready and able to start delivering services quickly. Others need to be commissioned, because drug and alcohol work for these organisations is quite new, and we want to make sure it succeeds.

I can say that over two-thirds of the Primary Health Networks have their activity work plans approved, and that means that they can start commissioning. We are negotiating with the others. We want to make sure that they can succeed and that we are not pushing them such that they have not had enough time to consult, to identify the right services and to commission in the right way.

All of the services will be required to commence commissioning by January next year, and some of them are ready to go now.

Senator POLLEY: Just to clarify: with what is a genuine concern within communities about the increased use of this drug, you cannot now give me a figure of how much money has actually already been spent on the front line?

Ms McGlynn: No, I cannot—

Senator POLLEY: So, has 10 per cent been spent—

Ms McGlynn: No, I cannot tell you that today because the services that have their activity work plans approved will not all necessarily be delivering services at the same time. They will come on board, as I mentioned, when they get their service providers in place, and that is more difficult in some areas than in others.

Senator POLLEY: So you would not be surprised then if I were to say the information I have is that no money has yet reached the front line?

Ms McGlynn: I guess that is a matter of the language that is being used—whether or not the funding has commenced. It may not have commenced in terms of services being provided, but, as I said, now that the plans are approved that will be soon and needs to happen by January next year. What I can say is that two-thirds of those PHNs have agreements—the green light—to start commissioning services, which means that money and services will flow.

Senator Nash: If I could just add to that? I think this is really important: one of the reasons we chose the PHNs as the model to roll this out is that they have the local knowledge to determine what is right in their area. As you would realise, it is not a one size fits all—what is needed in one community is different to another.

What we also wanted to do was to give them the capability to really understand what the priority needs were—so, rather than encourage them to say, 'Just get this money out the door quickly'. A bucket of money is not going to fix this. They needed some really considered plans in response to the issues in their region that they saw as a priority.

I do not think that in general—certainly, no-one has raised with me—there is any concern about the fact of the money rolling out and whether it has or it has not. They are actually just very pleased that there is this good work going on.

Senator POLLEY: Really?

Senator Nash: Yes, there is this good work going on. Because the bucket of money itself will not fix it, we have to make sure that we are addressing the priorities, and the PHNs needed some time to do that, to get their plans in place. I think people understood that.

Senator POLLEY: Well, I am gobsmacked! I do not know any community that is not experiencing real issues around the use of ice which are not—

CHAIR: This should be a question, Senator Polley, not statements.

Senator POLLEY: This is a question. It is that they are concerned that there has been no money delivered thus far to the front line. In fact, what the evidence you have given us here this evening is that we could very well expect that there will be no money received at the front line in these communities that need it before January 2017. And in light of the amount of public attention, media attention and in the chamber, relentlessly, about the need for the government—this is about the health of those communities—why could that money not have been rolled out before 2017 in January?

Senator Nash: And in answer to that, I absolutely agree with you that it is important we get this money out. We actually, though, want to make sure it is well targeted. I absolutely agree with you about the importance of this to the community, which is why the coalition government came up with $300 million to address it and the Labor government had not given a dollar to it. We want to make sure it happens properly.

Senator BILYK: On notice, can we get a list of the areas that are ready to roll and that have got money. If I understand correctly, you said that everyone should be ready to roll by January. So maybe I could get the commencement dates for those areas as well.

Ms McGlynn: We can take that on notice. Can I clarify on that point that all services need to be ready to be commissioning by January, but, as I mentioned before, that does not mean that the ones that have got their activity work plans approved and their money ready to go will not start before that.

Senator POLLEY: The National Ice Taskforce recommended that a set of guidelines should be developed to cover the specialist drug treatment sector. Is this happening and, if so, what progress has been made?

Ms McGlynn: I can report that we have gone to market for a centre of clinical excellence in emerging drugs of concern, so that will be a real focus of that area. As you know, ice is a drug that is of current concern, but there are emerging ones all the time. That is one area where we will look at not only developing a specialist response but also how we get GPs and other clinicians up to speed with how they might also support people on this drug and on other drugs. Also, there are some Medicare items that are ready to go from November for support for addiction medicine specialists.

Senator POLLEY: In relation to these minimum guidelines, will private treatment clinics be included?

Ms McGlynn: In relation to the private treatment clinics, we are looking at a piece of work around making sure we are clear about the quality of services that we fund. Because the guidelines have not yet been developed, the scope of those is yet to be determined.

Senator POLLEY: Is the department aware of issues with private treatment clinics where parents are paying large sums of money but are not getting the treatment results that are promised? I am sure you will be aware of that.

Ms McGlynn: We are aware of the clinical responses that we fund, yes. But other private organisations outside of that—

Senator POLLEY: You would be aware from the media in recent times that there are those parents who are paying a lot of money and are made promises, but the outcomes are very different. I would have thought that you would be aware of that. Can you tell me whether or not there are any plans, from the department's point of view, to increase regulation around private treatment clinics?

Ms McGlynn: As I said, we are looking at a whole range of issues around the quality of service provision in the drug and alcohol field.

Senator POLLEY: What is the average wait time for public drug and alcohol treatment? Can you give us the figures state by state?

Ms McGlynn: I do not have that information, but I can take that on notice. As you would appreciate, a lot of these services—about 70 per cent of services—delivered in the drug and alcohol space are delivered by the states and territories. I think it would be hard to get that information, but I am happy to take it on notice.

Senator POLLEY: Thank you. Does the department know how many people are on the waiting list for public drug and alcohol treatment?

Ms McGlynn: Again, I would have to take that on notice, for the same reasons.

Senator POLLEY: I assume you will take that on notice, but I can speculate that there are increased waiting times for public drug and alcohol treatment and that that is leading to families making the decision that they will have to pay to go to private clinics. Are you aware of any of the extra issues and stresses being placed on families? Some of them are having to mortgage their homes. I mean, there has been a fair bit of this covered in the media. I was just wondering if you are aware of that and whether that is in the psyche of what the department is looking at in terms of regulation and the timing around those issues.

Dr Southern: Yes, we are certainly aware of the media, which you are referring to, that is talking about those issues. I think we have to remember a couple of things: one is that, yes, there is additional funding through the ice strategy for additional alcohol and other drugs services. That comes on top of an existing investment that the Commonwealth makes in alcohol and other drug services—around $500 million or so, I think it is. But the primary responsibility for the delivery of these services is still with the states and territories. So there are a number of factors here in relation to access to the services that we would need to be contemplating as well.

Senator POLLEY: My final question in this area—you will be pleased to know, Chair—is whether the department is concerned that there could be an increase in the number of private providers trying to take advantage of the shortage of public beds available for treatment. Do you have an eye on what is happening in this sector?

Mr Bowles: We watch the media reports, as you have indicated. We have seen some of those sorts of issues. We are aware of some of those things. I think there is a broader point

here about commercial activities as well. We can look to regulate in certain circumstances, but clearly market forces do play a role in some of these sorts of things. I think your point is: how do we make sure we get quality outcomes? I think that is something we are quite conscious of.

Senator POLLEY: Great. Thank you very much.

CHAIR: Thank you, Senator Polley. Senator Di Natale.

Senator DI NATALE: I will follow on from that, for the sake of continuity. I cannot hang up my shingle, call myself a doctor and provide services if I am not a doctor, yet I can open up a drug clinic, call myself a drug counsellor and charge 30,000 bucks for someone to come and stay for a couple of weeks. Are you suggesting that that is just market forces at work?

Mr Bowles: No. I was making a broader point, Senator.

Senator DI NATALE: I suppose what I am asking is: is there any work being done to provide a level of accreditation to these practices, so that consumers have some peace of mind to know that they are going into an accredited clinic that conforms to a particular set of standards?

Ms McGlynn: We are doing some early work on the quality component of drug and alcohol services. We are aware that there is some variability and of the issues that you have raised, so we are looking at what those requirements might be. Also, we are very cognisant of the fact that, again, there are already some requirements under funding through states and territories for accreditation. So we are also looking at what is already available and how that can be strengthened.

Senator DI NATALE: Just to be clear about it: it is largely unregulated. The sector is largely unregulated. People and families have no way of knowing whether they are going to a service that is going to provide any benefit to people. Some of these people are shonks. Again, for the purposes of getting some clarity here, are you suggesting that you are doing some work in the area of just the services that you are funding, or are you doing work right across the sector to try and ensure that we get a uniform set of standards?

Mr Bowles: I think there are a couple of issues here. This is largely a state and territory regulatory issue not a Commonwealth one. We do not have constitutional powers to deal with some of these issues. That does not mean that we do not talk to our state and territory colleagues about some of the broader points, and that has been the case, but we have to recognise that the Commonwealth has limited powers in certain circumstances. So what we do in that context is deal with the states and territories in a broader sense and remind them—and they are working on this. They are aware of these sorts of issues. They are dealing with them all the time. They are dealing with the people who hang the shingle, as you described. It is a complex issue, obviously, and sometimes it does come back to our constitutional power to actually do something.

Senator DI NATALE: If you could provide us on notice with an update of any specific work that has been done in that area by the Commonwealth, that would be of benefit. Can I just ask you about the National Alcohol Strategy. What is the current status of the National Alcohol Strategy?

Ms McGlynn: The National Alcohol Strategy has been out for consultation; but, as you would appreciate, with the election and then caretaker and then the establishment of the new

ministerial forum on drugs and alcohol, that is something that will be taken to this new ministerial forum. It certainly—

Senator DI NATALE: How long has it been out for consultation?

Ms McGlynn: It started out for consultation at the end of last year. But because of the new governance—

Senator DI NATALE: October last year?

Ms McGlynn: Around that time, yes, I believe.

Senator DI NATALE: So it is a year now without an alcohol strategy or a drug strategy?

Ms McGlynn: The other one has lapsed, but it does not mean that we are not attending to that or working towards that.

Senator DI NATALE: We do not actually have a National Drug Strategy, though, do we?

Ms McGlynn: The drug strategy is also being revised.

Senator DI NATALE: Yes, but it has lapsed. We do not have one at the moment?

Ms McGlynn: That is right.

Senator DI NATALE: Has that also been out for consultation for over a year?

Ms McGlynn: For the reasons that I have mentioned, it will be going to the ministerial forum.

Senator DI NATALE: Aren't you flying blind a bit, if you are not operating with the current drug strategy?

Ms McGlynn: The strategy has been out for consultation, but it is not like the work that was done under the previous strategy disappears. It is actually updating the strategy. It is not that everything in the strategy will completely change.

Senator DI NATALE: But there was this huge response to the issue of crystal methamphetamine, with $300 million given to the task force, and we still do not have a national drug strategy. We do not have an operating national drug strategy. It gives a sense that the Commonwealth has vacated this space.

Ms McGlynn: I think there is evidence to suggest that the Commonwealth is very active in this space, given the previous discussions.

Senator DI NATALE: We had the Australian National Council on Drugs, which was effectively disbanded. We had the defunding of the Alcohol and other Drugs Council of Australia. That was replaced with ANACAD?

Ms McGlynn: Yes.

Senator DI NATALE: ANACAD is a black box, as far as I can tell. Do we have any information that can be shared with the Senate on the activities of ANACAD?

Ms McGlynn: We can take that on notice.

Senator DI NATALE: So you do not publish any ongoing updates, reports, given that it is the only forum through which advice is being provided on the response to alcohol and other drugs? I do not know what they do. I do not think any of us know what they do. We have lost the ANCD; we have lost the alcohol and drug council, and we have this thing called

ANACAD that has been operating for god knows how long, and no-one knows anything about it.

Ms McGlynn: I think the other thing that you will support, in terms of what is going on there, is the ministerial forum. Again, there will be advice provided to them and from them, and they will work closely with their justice and community law enforcement colleagues. So I think that that is another response that will see some of that information flow.

Senator DI NATALE: Who is actually on ANACAD? Is who is on the committee publicly available?

Dr Southern: Yes, it would be publicly available.

Senator DI NATALE: Can you provide the names of the people on notice.

Ms McGlynn: Certainly.

Senator DI NATALE: How many of the members on ANACAD are actually involved in specific drug treatment or the provision of harm reduction services? Do you have that information?

Dr Southern: Not in front of us, but when we come back on notice with membership of the committee we can indicate those members that do have that expertise. But there certainly is that expertise on the council.

Senator DI NATALE: I will wait to get it, as I would be interested to know. Given that it is a committee that is responsible for providing advice, it would be very interesting to know who is actually on that committee. Are there any consumer groups represented on ANACAD?

Dr Southern: We do not have their affiliations.

Ms McGlynn: We can provide that on notice.

Senator DI NATALE: My understanding is that there is no consumer representation, but I will be interested to hear if there has been any change to that. Was there a recent appointment of Mr Pat Daley. Has he been recently appointed to ANACAD?

Ms McGlynn: Not recently, no.

Senator DI NATALE: When was he appointed?

Ms McGlynn: He is a member.

Senator DI NATALE: What expertise does Mr Daley have on the issue of alcohol or other drugs?

Ms McGlynn: I believe he has a law enforcement background.

Senator DI NATALE: He is an antidrugs crusader is he?

Ms McGlynn: I would not characterise him as that.

Senator DI NATALE: Is it true that Mr Daley was a member of Tony Abbott's electoral committee?

Ms McGlynn: I am not aware of that.

Senator DI NATALE: Could you take that on notice?

Mr Bowles: People's political affiliations is not something we would delve into.

Senator DI NATALE: If we are talking about somebody who has a role like that surely that would be a potential conflict in providing independent advice to government.

Mr Bowles: As long as people declare their conflicts of interest when they are doing that. But having political affiliations does not necessarily mean that.

Senator DI NATALE: You think it is appropriate to have somebody who is an antidrugs crusader, who was a member of Tony Abbott's electoral committee, to be providing independent advice to government on issues around alcohol and other drugs.

Mr Bowles: That is not what I said.

Senator DI NATALE: That is what I am asking.

Mr Bowles: I am not sure it is appropriate that we get into some of these political issues. We are public servants.

Senator DI NATALE: It is the purpose of estimates. I think it is entirely appropriate.

Mr Bowles: We are public servants. You can ask the politicians about that.

Senator DI NATALE: It is not a political question. It is a question of independent advice being provided on the issue of alcohol and other drugs. It is about the specific expertise of the individuals involved.

Mr Bowles: He is on a committee.

Senator DI NATALE: Providing independent advice to government and informing government policy.

Mr Bowles: Along with a range of other people I presume.

Senator DI NATALE: I am asking what his particular credentials are.

Mr Bowles: We said we would take it on notice and give you a list of the committee members and their credentials.

Senator DI NATALE: Who appoints members to the committee? How are they appointed?

Mr Bowles: Ultimately this is a matter for government decision.

Senator DI NATALE: I might ask the minister, how are those appointments made?

Senator Nash: I will take it on notice. From memory, I think, I approved the members of the committee. It was some time ago now and I am not in the portfolio anymore. It was chosen to have a really good balance of various expertise across the committee. We did keep, from memory, some of the members from the previous committee. We brought them on to the new committee and then added some extra expertise through the other members. We will get that detail for you.

Senator DI NATALE: What are the terms of service? How long are they appointed for.

Ms McGlynn: I will have to take that on notice.

Mr Bowles: We will add that to the question on notice.

Senator Nash: I do not want to stop your line of questioning, but I want to put on the record what a tremendous job they have been doing in providing advice to the government and to the department. The broad set of skills that they have has been incredibly useful.

Senator DI NATALE: We will have to take your advice on that, Minister, because we do not know.

Senator Nash: I do, and that is why I am putting it on the record for you, Senator. We are happy to take all of this on notice for you. I want to be really clear that the level of expertise that they have been providing has been excellent.

Senator DI NATALE: Our job is not to just take that on trust. The point of estimates is to ensure we get some confidence that this is happening, so that is the reason for asking.

Senator Nash: Absolutely. I understand completely.

Mr Bowles: We will take that on notice to provide that.

Senator DI NATALE: Is this advice provided publicly? Is the advice that is being provided available to the public? Are minutes of meetings kept? Are we able to access the sort of advice that is being provided?

Dr Southern: There are certainly records of the meetings and they are kept. But it is an advisory council for the minister.

Senator DI NATALE: So there is no means to independently access the—

Dr Southern: They are not published, no.

Senator DI NATALE: How do the reporting requirements differ from the previous ministerial council on drugs?

Dr Southern: I would have to take that on notice. I was not around when the previous council was operating, so I am not sure of those arrangements.

Senator DI NATALE: Going back to the question of flexible funds—this may be an area you need to take on notice as well—given that a number of the flexible funds were specifically targeting this area, drug treatment, do you have this information available? It would be interesting to know whether the existing funds were all rolled over into this outcome, and the quantum of funding for those compared to what was previously allocated.

Dr Southern: My understanding is that there were two flexible funds which dealt with alcohol and drug services, research and a couple of other things and both of those have collapsed into one of the programs in outcome 2.4.

Senator DI NATALE: I know that with one of them the funding was only secured for a year. Has the funding continued beyond that?

Dr Southern: The funding for the alcohol and other drugs service—not the ice money but the existing money—has been extended through until 30 June next year. The arrangements for ongoing funding are something for government consideration between now and then.

Senator DI NATALE: So it is a year by year proposition at the moment?

Dr Southern: The previous contracts, I understand, would have been for three years and this was a one-year extension while—

Senator DI NATALE: I think there was one-year extension after the three. This might the second one-year extension.

Dr Southern: It may well be. The intention would not be that we move to a one-year-by-one-year arrangement.

Senator DI NATALE: It is impossible for these organisations to do any planning, to recruit, to keep staff, if all that is happening is they are given year-by-year funding.

Dr Southern: Yes, that is right. As I say, by extending it for one year, it was in part to consider how the rollout of the additional funds through the PHNs was going and how that would operate and then to see how services might be funded from 1 July onwards.

Senator DI NATALE: Has any work at all been done by the department to look at harm reduction measures such as pill testing?

Dr Southern: No.

Senator DI NATALE: Can I ask about the rollout of naloxone treatment for overdose? Does the federal government have a role in that?

Ms McGlynn: That is something we have considered and we are looking at the evidence of that. Again, that is something that would well be in the remit of the clinical centre for excellence as well, because there is varying evidence and I think it is something that the clinical and research community really need to provide some advice on.

Senator URQUHART: I have some questions in relation to the Mersey Community Hospital. In the March estimates round, the department confirmed that the budget included $62.7 million a year for the Mersey Community Hospital in 2017-18 and 2018-19. Is that still the case?

Mr Cormack: Yes. It is still correct, but what is reported in MYEFO is that $2.61 million of that is retained by the department to meet expenses incurred in the course of ownership of the Mersey such as insurance, worker compensation and legal and consultancy costs. So the direct payment, if you like, to the provider is $62 million less those expenses.

Senator URQUHART: How about in 2019-20, given that that is now within the forward estimates, what is the funding for that?

Mr Cormack: It is basically the same figure.

Senator URQUHART: So the $62.7 million?

Mr Cormack: Yes, that is right.

Senator URQUHART: So that is locked in for the—

Mr Cormack: For 2018-19 and the forward estimates.

Senator URQUHART: What about for 2019-20, given that that is now in the forward estimates?

Mr Cormack: That is the same.

Senator URQUHART: That is locked in in the forward estimates?

Mr Cormack: The current contract expires at the end of this financial year.

Senator URQUHART: June 2017.

Mr Cormack: But there is a forward provision in the budget, equivalent to the amount that you mentioned, in the forwards.

Senator URQUHART: So there is a forward provision of $62.7 million for 2019-20?

Mr Cormack: Which is different to the amount they are getting now, under the current contract arrangements.

Senator URQUHART: What is the amount variance?

Mr Cormack: The allocation is $75.5 million for 2016-17.

Senator URQUHART: Let me get this really clear—so for 2017-18, it is $62.7 million?

Mr Cormack: Correct.

Senator URQUHART: For 2018-19, it is $62.7 million?

Mr Cormack: That is right.

Senator URQUHART: And for 2019-20, is $62.7 million locked in?

Mr Cormack: That is right. I have not got that presentation in front of me so I will confirm that, but that is what I believe to be the case.

Senator URQUHART: When you would be able to confirm that?

Mr Cormack: We will get that to you before close of proceedings today.

Senator URQUHART: Thanks very much. When the health minister was in Tasmania last month, she was asked about ongoing funding for the Mersey and she said: 'I am not going to make commitments. I am not going to pre-empt what decisions might be.' If there is money in the budget, why did the minister duck the question?

Mr Cormack: I cannot answer your report of what the minister said. Let me be clear about that. What I can do is tell you what the situation is. We currently have a provision out in the forward estimates, as I have described. We have a two-year arrangement in place which concludes at the end of this financial year and is the 75.5 million figure that I mentioned earlier. We are in negotiations with the Tasmanian government—and that was, presumably, part of the purpose of the minister's discussions with Minister Ferguson—to progress what arrangements will be in place at the end of 16-17. So we cannot say what is going to be in place. We have got a two-year—

Senator URQUHART: But you have got a provision there for it.

Mr Cormack: We have got a provision there in the out years for that—

Senator URQUHART: Out as far as 2019-20.

Mr Cormack: Yes; as I said, I will confirm that because I do not have that piece of paper in front of me. I will confirm that before close of proceedings tonight.

Senator URQUHART: And—I think you have done this, but I just want to get it clearly on the record—can you confirm that funding will continue beyond the current heads of agreement which expires in June 2017?

Mr Cormack: There is a provision of funding for the Mersey in the budget. That is what I am saying. We have a contract with the Tasmanian government for management and delivery of the services that expires in 2016-17, and we are in negotiations with the Tasmanian government—

Senator URQUHART: No; I understand about the negotiations. But my question was: can you confirm that the funding will continue beyond the expiry of the current heads of agreement? It is a simple yes or no answer, surely.

Mr Bowles: No, it is not, Senator.

Senator URQUHART: Okay; why is it not?

Mr Bowles: There is a funding allocation there, but it is subject to the negotiated outcome with the Tasmanian government.

Senator URQUHART: So there is a funding allocation there.

Mr Bowles: Yes.

Senator URQUHART: You then have to have negotiations.

Mr Bowles: Correct.

Senator URQUHART: So you cannot guarantee that that funding will go forward until those negotiations are complete. Is that correct?

Mr Cormack: The—

Senator URQUHART: Sorry; I don't want to put words in your mouth. I am trying to clarify.

Mr Bowles: Well, let me give my words then. We have a contract in place till June 2017—75.5 million—for a range of service and deliverables that, as far as I am aware, they are meeting fully at this point in time. Beyond that point the contract lapses. But what we have in the budget is a provision for ongoing funding for the Mersey arrangements. The shape, nature, size, mix of services that will be reflected after 16-17 is a matter for negotiation, and it is not a matter that I can speculate on beyond what is already on the public record, which is what the budget papers say is provided for. That is as much as we can say, Senator.

Senator URQUHART: Great, that is very clear. Thank you for that. And those negotiations are between the Commonwealth and state governments, is that correct?

Mr Cormack: That is correct.

Senator POLLEY: Can I just ask, is that because of the review that is taking place by the state government around health in Tasmania?

Mr Bowles: No. As the committee knows, we are responsible for the Mersey hospital, and we have entered into a contractual arrangement with the Tasmanian government to deliver services from that hospital. That is the arrangement that is in place.

Senator URQUHART: And then the rest is up to the—

Mr Bowles: That is exactly right.

Senator URQUHART: Can you at least advise on the current state of negotiations, and what you believe to be an expected time line for a resolution?

Mr Cormack: What I can say is that the negotiations are ongoing. The negotiations are frank and cordial.

Senator URQUHART: I think someone said that back in March.

Mr Cormack: Yes, that is right. They continue. They are frank and cordial. We need to take into account that Tasmania is responsible for public hospitals and service delivery for the state of Tasmania. They have released a plan. They have foreshadowed and announced changes to the service profile of the Mersey Hospital. They and other factors will be taken into account when we come together and sign off on some kind of arrangement for the ongoing delivery of services related to the Mersey Hospital. But the shape and content of that is subject to negotiations, so we cannot speculate on what that would be.

Senator URQUHART: I am not asking you to speculate. I am asking you whether you can tell me when the expected time line for a resolution is.

Mr Cormack: The current contract—

Senator URQUHART: When did the negotiations commence?

Mr Cormack: I will have to just double-check on that. The current contract expires on 30 June 2017. So we will need to have some form of service arrangement in place before that expires.

Senator URQUHART: Before June 2017?

Mr Cormack: That is correct. We will need to have some arrangement in place. I cannot speculate on what that will be for the reasons I just referred to.

Senator URQUHART: It is a little over seven or eight months away. The reason I am asking this question is that there are many employees at that work site who, right at this stage, are very unclear about what their future employment opportunities will be within that hospital. The longer these negotiations go on, the unknown quantity of what is going to be in those negotiations and also the unknown time frame make it very unsettling for them.

Mr Cormack: I completely understand that.

Senator URQUHART: It is also very unsettling for the whole health area around north-western Tasmania, because it is very difficult to get specialists to come and plant their boots for a long period of time if they do not know what the future will be.

Mr Cormack: That is right.

Senator URQUHART: What is the Commonwealth doing to try and speed up those negotiations and get a resolution as quickly as possible to put certainly those workers at ease?

Mr Cormack: The Commonwealth is negotiating with the Tasmanian government for the future shape and services of the Mersey Hospital at the end of the contract. So we are progressing those as quickly as we can.

Senator URQUHART: But aren't you providing the money? Why are you negotiating the shape and services? Why are you not just handing the money to them?

Mr Cormack: Because these are Commonwealth funds. We have a contract in place that expires—

Senator URQUHART: So you negotiate around what exactly they can spend that money on?

Mr Cormack: They need to put it forward, because they have now completed a plan for the state. They have a view on what should be provided in that part of Tasmania, and that needs to be taken into account in what happens at the end of June 2017. It cannot simply be frozen in time as it has been. It will need to reflect the state government's constitutional responsibilities for the delivery of public hospital services in Tasmania, not what the Commonwealth wishes to impose upon it.

Senator URQUHART: I did ask if you had a date on when the negotiations commenced. Have you got that?

Mr Cormack: They commenced in May 2016. I have already given an answer to you on when we hope to conclude those.

CHAIR: Just in the one or two minutes remaining, I have a quick question on that issue myself. I wonder whether the department or the minister's office has a list of representations received from federal members of parliament from the state of Tasmania?

Mr Cormack: We will certainly take that on notice. I am sure there have been a number. I do not have that available to us at the moment.

CHAIR: Sure. Just, say, for the last three months.

Mr Cormack: We will see what we can do.

CHAIR: Thank you.

Senator POLLEY: Can I seek some clarification?

CHAIR: Sure.

Senator POLLEY: We still need to deal with mental health in outcome 2. I have some questions now, because Senator Bilyk had other responsibilities to deal with palliative care. Are we going to come back after dinner and go straight into mental health? Is that the plan?

CHAIR: The plan would be to go on with program 2.1, mental health, and move to 2.3, health workforce, and then we would work through, skipping over 2.4 that we have already done, and finish off outcome 2 in record time, I am sure.

Senator POLLEY: Is there any chance of having some sort of agreement—because I know that the aged care officers have been here, waiting, even though I did attempt to have some questions asked this morning—about a time to make sure that we get through the agenda?

CHAIR: I am in the committee's hands. We can meet very briefly after we suspend the committee for the break, if you would like to look at some sort of agreement? Would that work for you?

Senator POLLEY: That would be great.

Mr Bowles: During that conversation, if there are any areas on here that you do not have any questions for, I can at least send people home, because we are at least two hours to behind.

CHAIR: I am very cognisant of that. We have asked that question, but, unfortunately, at this stage it appears that everyone is required. We will advise as soon as possible though.

Senator POLLEY: We have taken out a whole raft of questions on a range of areas, just so we can make up some time so we can get to aged care.

Mr Bowles: I accept that, but after aged care we have all the sport issues, regulations and a whole range of other things.

Senator POLLEY: Sport is still on the agenda.

CHAIR: Thank you very much.

Proceedings suspended from 18:30 to 19:31

Senator SIEWERT: Some of my questions cross into the PHN delivery, but I figure it is better asking you because some of it is about the actual policy rather than about the delivery of the PHNs. Does that make sense?

Mr Cormack: We do both.

Senator SIEWERT: Okay. I have had quite a lot of feedback about PHNs virtually being told that they cannot work on psychosocial services. Is this in fact the case? If so, why?

Ms Cole: It is actually a little complicated, in the sense that there is a flexible funding pool which has a number of clinical programs which were brought to the PHN. Of those, most are not meant to do psychosocial support. There are some exceptions in the guidelines provided with that flexible funding, particularly around suicide prevention and the severe end of the spectrum. There are a number of PHNs that do actually deliver psychosocial support through the Partners in Recovery program. In a sense, the issue is ensuring that the funding which was set aside by the parliament for clinical services continues for clinical services, although the format of that might change as we move to a stepped care model, noting that in some circumstances there will need to be a psychosocial support component as well.

Senator SIEWERT: That opens up a whole range of other questions. I will first go to: where do you expect the psychosocial services to come from if the PHNs cannot deliver them? I am thinking particularly of those people who do not get access to NDIS.

Ms Cole: Psychosocial supports are primarily provided in the department through two programs: Partners in Recovery and Day to Day Living. Both of those—

Senator SIEWERT: Yes, exactly. And they are both closing down.

Ms Cole: are going into the NDIS.

Senator SIEWERT: Yes. But the issue here is—let's jump into that issue right now—in terms of the NDIS, there was only ever a certain proportion of those with mental health issues who were going to get packages out of NDIS. And tell me when I cross into NDIS territory per se, and I will ask that tomorrow. I know that it goes between the two. We know there is only a smaller cohort of people that are going to get full packages under NDIS, and I understand—and I will ask this tomorrow—that at the moment there are fewer than expected. So there are still a hell of a lot of people—sorry, technical term—there are a lot of people who need supports when Partners in Recovery transitions in and Day to Day Living. Where are these people who need that support going to get it?

Mr Cormack: You asked us to tell you when you crossed into the other policy area. You have just done that. It is a DSS matter.

Senator SIEWERT: I cannot let you get away with that. This is a government policy.

Mr Cormack: Yes.

Senator SIEWERT: I know that you are going to go to ILC. There is not enough money in ILC to address even just mental health, let alone every other disability. So it is a policy issue for government. Where is that support going to come from?

Mr Cormack: The policy responsibility for the NDIS rests with another government department and another minister. What we are doing as a health department is working closely with our colleagues in DSS to ensure that there is a smooth transition to the program—that we are able to identify any potential issues that may emerge—

Senator SIEWERT: Not 'may'; 'will'.

Mr Cormack: throughout the transition process, and we will work closely with our colleagues to inform whatever government response may or may not be required to deal with what you are talking about.

Senator SIEWERT: I feel the frustration that I know the community is feeling because I have done a lot of consultation since I took this portfolio back over. They are so frustrated at that type of response. We know the cohort of people with mental health. We know how many people are going to get packages. We know the funding for ILC is limited. We know Partners in Recovery is going into NDIS. We know Day to Day Living is too. Sorry, I just cannot let you get away with saying, 'Well, it now belongs to another department.' You are the Department of Health.

Mr Cormack: What we are saying is the policy responsibility for the NDIS rests with another government department. That does not mean that we are disinterested. It does not mean that we do not care. It means that we are working very, very closely—we have already got existing responsibilities for a number of the programs that will be transferring across to the NDIS. It is just that we do not have the policy responsibility as an agency to resolve and answer the question that you are asking. But we do have a responsibility as part of the Australian government and the Australian Public Service to work with our colleagues to inform whatever government response may or may not be required to facilitate the transition.

Senator SIEWERT: So what you are saying is that you, after the full rollout, will have no further responsibility as the department for mental health.

Mr Cormack: I did not say that at all.

Senator SIEWERT: That is certainly how you come across. I am sorry. The way it came across was: 'That is all transferring to NDIS, so we cannot talk about it anymore.'

Mr Bowles: No. What was said was the policy responsibility for these areas is transferring. We are still engaged in this conversation and we are engaged quite deeply with DSS as we speak. Ultimately, there are some programs that we currently run that will move to the NDIA. Once that happens, it is their policy responsibility. The government intent is to move them. We are working with them how that will transition.

Senator SIEWERT: But you have said Partners in Recovery is moving—

Mr Bowles: Partners in Recovery and the other one you mentioned—

Senator SIEWERT: Day to Day Living.

Mr Bowles: Day to Day Living. They are the two that will move into the NDIA.

Senator SIEWERT: But you know full well that NDIS will not be providing the coverage—

Mr Bowles: And that is why we are working with DSS today to work out whatever gap may or may not happen—you say 'will happen'; we say 'may or may not happen'—and we are working with DSS how we will cover that. It could pan out to be that they are covered under a DSS program. It could pan out that it is covered under the NDIA and Health. We do not know. That is part of the process we are working through.

Senator SIEWERT: So DSS get the policy responsibility for mental health—as of when?

Mr Bowles: No.

Mr Cormack: No.

Mr Bowles: No. They have the policy responsibility for the NDIS.

Mr Cormack: There are four mental health programs, Senator, and you know what they are.

Senator SIEWERT: Yes.

Mr Cormack: The policy response for two of those already rests with DSS. The other two, Partners in Recovery and Day to Day Living, rest with Health. All four policy responsibilities transfer into the NDIS under the policy department of DSS.

Senator SIEWERT: So my question still stands: what time frame have you got, what processes are in place to the policy, for those that—

Mr Bowles: Yes. That is what we have just been talking

Senator SIEWERT: We already know psychosocial is not being covered by PHNs.

Mr Bowles: That is what we have just gone through.

Senator SIEWERT: Yes.

Mr Bowles: We are working with DSS on that transfer of arrangements which I think is due to start in about 2019.

Unidentified speaker: Full scheme.

Senator SIEWERT: Full scheme 2019.

Senator SIEWERT: What specific processes have you got in place and have you done the figures on who is not—are you finding funding for it?

Mr Cormack: We are working closely with DSS. Obviously, together, we will learn from the more mature transition jurisdictions as to whatever impacts may or may not result—the ACT, for example, is ahead of us. So we will learn from that and we will respond in partnership with our colleagues in DSS to inform whatever government response is required to address any resulting gap that may result. So we do not—that is what we are doing.

Senator SIEWERT: Knowing full well that there are going to be issues—you do not have to have a complex understanding of the system, which I grant you is quite complex, to know—just looking at the figures to date, there will be people who will not be covered and there will be gaps.

Mr Bowles: We are not disagreeing with anything you are saying. We are telling you how the process is working and the fact that we are working very closely with Social Services on how this will actually happen in its fullness.

Senator SIEWERT: But it is once the gaps happen.

Mr Bowles: No.

Mr Cormack: No. We are working with them now. But they have policy responsibility for this program. We are deeply engaged with our colleagues in DSS and we will assist, advise, inform and be engaged in whatever additional government response is required to respond to any gap that may or may not result.

Senator SIEWERT: Okay. When you have been working with DSS, have you been consulting stakeholders at the same time?

Mr Cormack: Yes.

Senator SIEWERT: Which ones?

Mr Cormack: We have had discussions with a number of stakeholders. We have discussions with the states. The secretary and myself are regular attenders obviously at AHMAC. This matter comes up at AHMAC. It comes up in the principle committees. We have discussions with Frank Quinlan and Mental Health Australia as the peak body. We are in regular dialogue over this particular issue. It is also a key element that is certainly part of the Fifth National Mental Health Plan and how that is going to pan out. So this is not something that we are just flying blind on. We are deeply engaged and are looking to respond as appropriate should there be any specific gaps that need to be filled.

Senator SIEWERT: Thank you.

Senator POLLEY: Can I just ask a follow-up question on that. Bearing in mind that this has been in the planning for some time, have you actually considered the number of people that we can expect will fall through the gaps and has any funding been allocated to ensure those people are not left without support?

Mr Cormack: I will repeat my earlier response. We are working with the responsible policy department—

Senator POLLEY: I know that you said that.

Mr Cormack: and there is no additional funding available to this department to respond to any gap that may or may not result because it has not—

Senator POLLEY: So no funding?

Mr Cormack: No, we are responsible for two programs—

Senator POLLEY: Yes.

Mr Cormack: They are going to novate or transfer into the NDIS, and we have already discussed those. That funding remains there. Should there be any gap that emerges that requires a government response to fill any gap, then that will be a matter for future consideration by government. We will work closely with the policy agency that has responsibility for that to give them all the information that government needs to make any necessary adjustments, should it need to do so. But we do not have policy responsibility for that. You need to be talking to DSS.

Senator POLLEY: Okay.

Senator SIEWERT: And we will follow that up tomorrow.

Senator POLLEY: We will.

Senator SIEWERT: I want to go back to where I started, which is the PHNs. It is my understanding that people who are currently receiving funding support through Partners in Recovery and Day to Day Living will continue to receive that funding. Is that a correct understanding?

Mr Cormack: Yes

Senator SIEWERT: But we do have a disconnect between the funding that has now gone to the PHNs and the understanding that they cannot do psychosocial specifically.

Ms Cole: I am not quite sure what your question is.

Senator SIEWERT: My question is: what happens to new people that need support from Partners in Recovery before NDIS starts rolling out in their parts of the world?

Ms Cole: There are essentially two ways those people might be handled. One might be that if they are in a region the NDIS is being activated they can go straight into the—

Senator SIEWERT: I am assuming it is an area where is has not got to them yet.

Ms Cole: Yes. The other area is that Partners in Recovery organisations are able to take new clients as they are transitioning clients out, noting that the program was never meant to be a forever program. The Partners in Recovery program was always about establishing the networks around an individual, whether it is in housing, clinical services, et cetera, and then transitioning them into those services.

Senator SIEWERT: I understand that. If people are not going off into NDIS, for that group that are new and not yet in an area where they are able to access NDIS, can existing providers take people on until the NDIS gets to them?

Ms Cole: That is correct, as long as they are within their cap, noting that it is a capped program. That is a significant difference between NDIS and PIR.

Senator SIEWERT: Is it the same with Day to Day Living?

Ms Cole: Yes, but Day to Day Living is a little bit different, because there is more fluidity in the client numbers, because it is around activities for people who need some assistance.

Senator SIEWERT: Yes, but will they be able to in the meantime receive those services?

Ms Cole: Yes.

Senator SIEWERT: What happens then with people where the NDIS is being rolled out? I understand they would go to NDIS. They do not then get the support through the NDIS, because only a certain percentage do. What happens then?

Ms Cole: If they are not eligible then they are not eligible.

Senator SIEWERT: Sorry, but are you saying that anybody that is eligible for Partners in Recovery will be automatically eligible for NDIS?

Ms Cole: No, I am not saying that.

Senator SIEWERT: No, I did not think you were. They are not sick enough to get NDIS and to get the full package, and therefore they get nothing. That is what people are worried about.

Ms Cole: Absolutely.

Senator SIEWERT: Because only 12 or 14 percent of people with mental illness are going to get a package.

Ms Cole: The numbers in Partners in Recovery are actually relatively small, and at the moment the transition rate is about 90 percent on the trial sites.

Senator SIEWERT: Hang on, I have a question there. That is of people that apply. That is what I will be asking NDIS tomorrow, because in some places it is the number of people in Partners in Recovery who actually apply, not the full cohort of people receiving Partners in Recovery.

Ms Cole: The Partners in Recovery organisations are strongly encouraged to assist people to apply, because it is felt that this is a natural cohort for the NDIS. In terms of the eligibility of the NDIS, I think this is actually a series of questions you need to ask tomorrow.

Senator SIEWERT: I partly take your point, but the point still stands. Particularly when we are rolling it out, what happens to those that do not get support through a full package through the NDIS?

Ms Cole: There is a continuity of support requirement for all governments, remembering that we are not the sole providers of psychosocial support. There are also the two programs run out of DSS currently, plus there are state and territory programs.

Senator SIEWERT: Which two programs are you talking about?

Ms Cole: There are two programs in PHaMs—

Senator SIEWERT: I just wanted to check you are talking about PHaMs.

Ms Cole: The other thing to keep in mind is that the states and territories actually provide a lot of psychosocial support.

Senator SIEWERT: I knew you were going to go there. And a lot of them are winding back their funding too?

Ms Cole: I cannot comment on what the states or territories may or may not be doing.

Senator SIEWERT: I will ask the NDIS tomorrow, but they are winding back their funding for some of their mental health supports the same as they are for other disability supports.

Senator POLLEY: So there is still a risk of a cohort of people being left behind.

Mr Cormack: It is not the purview of this portfolio to deal with Commonwealth-state agreements outside of that policy area. We will provide advice, guidance, support and engagement to identify any potential gaps that may emerge, but you are asking us about policy responsibilities of another government department, and it is going to get very frustrating for both of us if we continue along this path.

Senator SIEWERT: I will be continuing it tomorrow, but it is an issue for government as a whole. There is a group of people who are going to fall through the gaps that you are not looking at, so we will see if DSS is and see if NDIS is.

Mr Cormack: We are looking at it. I did not say we are not looking at. I am just saying it is—

Senator SIEWERT: You cannot tell us the numbers.

Mr Cormack: We are working with the agency that has the policy responsibility for the transition.

Senator SIEWERT: I realise I am not going to get much further. I know that we have limited time—

Senator POLLEY: Can I just ask one question then about the responsibility that the health departments have for mental health and caring for these people and supporting them today? I understand the policy is changing to another ministry, but surely there would have been some modelling done about the danger of people being left behind and not getting the support that they need. Surely there has been some work done on that?

Mr Cormack: We work on an ongoing basis with our colleagues in DSS to ensure that there is a smooth transition from the current arrangements into the full-blown NDIS. We are not just sitting around waiting for it to happen; we work closely with them. As I have said

before, the policy responsibility for planning for this transition and resourcing it is the department that you are going to be talking to tomorrow, not this one.

Senator POLLEY: It is not very reassuring for those people who are living with mental illness, but we will move on.

Senator SIEWERT: Can I touch on the headspace issue and the comment that was made in January about headspace—that the PHNs will be asked to continue current sites and services for a two-year period and that they will have to satisfy the Minister for Health and Aged Care if they want to move away from the headspace model. Just so we can get that crystal clear, does that mean that if the PHN does want to move away from the current headspace model, it can?

Mr Cormack: You are talking about two different policy authorities. Let me clarify what they are. The government's response to the National Mental Health Commission's landmark report included transferring responsibility for the contracting of the headspace centres to the PHNs, and that is guaranteed under that policy authority for the next two years.

Senator SIEWERT: Two years—I understand.

Mr Cormack: That is right. That is obviously before the conclusion of that period, and then it is the PHN's responsibility to commission appropriate youth and young persons' mental health services. So that is the model, and that is what was announced in November. In the context of the election, the Prime Minister further clarified their intent. I will summarise what I believe they said, and that is that headspace is the Commonwealth's national youth program—

Senator SIEWERT: Flagship program.

Mr Cormack: Absolutely. I think words to the effect that you asked in your question would apply. In the context of converting election commitments into formal policy decisions, we are in that process now with a number of election commitments in mental health. But we heard that just as clearly as you did and we will work that through with the government when they finalise all of their election commitments.

Senator SIEWERT: Okay, thank you. Have any PHNs indicated to date that they do not want to continue with the current headspace?

Ms Cole: No.

Senator SIEWERT: They have not? Okay, thank you.

Senator O'NEILL: Yesterday, during consideration in detail, Minister Ley said the following:

> I noted in my previous answer, we have undertaken to provide 10 more headspace centres as part of our election commitments and my intention is that they go in the areas that need them.

You are nodding your head, so I am sure you are familiar with that. As this was a decision that was made by the Prime Minister during the election campaign, I am assuming that you had already completed the assessment work to identify why another 10 headspace centres were needed. Is that correct?

Ms Cole: There is a model that we have, which headspace national office also used, which has identified a number of locations where, if there were an opportunity for additional funding, you would potentially put a headspace centre.

Senator O'NEILL: Let me unpack a little bit of what you said. You used a model—

Ms Cole: No, there is a model.

Senator O'NEILL: There is a model?

Mr Cormack: Headspace National.

Senator O'NEILL: Yes—was using when?

Mr Cormack: They clearly have a view. We have the existing headspace centres. I think there is certainly formal recognition that there should or could be more, and headspace, as the proprietor of that model, has had a look at where the next 10 or 20 or 30 might be, based on their detailed understanding of needs. They have formed a view. The government has made an election commitment, and that has yet to be translated into the formal identification of exactly where those 10 sites will be. The process of doing that will be the normal process of government decision making, which is a cabinet process. We will provide information, but as it is a cabinet matter we cannot speculate on where those sites are going to be. There were some comments made in the course of the election campaign, but the government is yet to make a decision as to where those 10 will be. We will provide advice in the context of the government decision-making process.

Senator O'NEILL: To be clear, the number 10—was that proffered as part of the plan going forward by headspace itself, using their model? Where did the number 10 come from?

Mr Cormack: It was an election commitment. The government made an election commitment, and we do not inform election policies. They are made by the party, and they were announced during the election campaign. No doubt we will continue to be asked for advice on where those centres should be, and we will provide that advice in the context of a cabinet decision that has yet to be taken.

Senator O'NEILL: At this point in time, the criteria that have been applied are the headspace model. Do you have additional criteria that you are applying, now that it is a matter for government?

Mr Cormack: Headspace are clearly the experts in this area. They will have a very clear view as to where those sites should be. The department will also provide advice to government as to where those 10 additional sites could be. The ultimate decision is a matter for government.

Senator O'NEILL: Will you be developing criteria that are independent and separate from headspace?

Mr Cormack: We will provide advice to government about possible locations that will be independent of headspace. We will obviously take into account where headspace determines or has envisaged the next 10 locations should be. We will have a look at those; we will have a look at it from the point of view of the current spread and accessibility of headspace centres across the country. But the decision about where the next 10 will be is a matter for government. It has not been taken yet. We will provide advice, and government is free to take advice from whoever else they wish in formulating the choice of the next 10 sites.

Senator O'NEILL: You have just indicated one of the elements that I assume would be part of the criteria, the geographical location of these things.

Mr Cormack: You are talking about criteria. What we are saying is that headspace has a model, and they understand the territory pretty well; I think we have to accept they know that. We do not have a working model independent of that, but we have a look at population need, the availability of other services and any other information that we have been able to gather in the course of our involvement in running and managing mental health policy and programs.

Senator O'NEILL: Would you say it is fair then to say that you are in the process of developing the criteria, but there is not one yet established?

Mr Cormack: We are ready and able to prepare advice for government on the location of any additional headspace centres that they wish to commit to. In doing that, we will gather information from a wide range of sources, along the lines that I have just mentioned, including, obviously, seeking advice from headspace, who clearly know this territory very well.

Senator O'NEILL: But is there a set of criteria developed—

Mr Cormack: There is not a formal criteria, but there is obviously a lot of planning information available to us that can provide guidance to us. But there is not a rock-solid, push-a-button 'Here's where the next headspace centre goes' model that we have available to do that.

Senator O'NEILL: So it is pretty fluid really at this point?

Mr Cormack: No. It is well informed. It is based on information from a lot of sources. It is an assessment of needs. Obviously we have now got 31 PHNs who can give us good on-the-ground intelligence about what is going on in their areas. They have just completed needs assessments. That is another useful source of advice, but it is not a rigid formula that is applied. We look at a number of different sources of information and guidance in providing advice to government.

Senator O'NEILL: As a department, have you undertaken any work around need in relation to these 10 new headspace sites? You just indicated needs analysis, but I am assuming that was at a PHN level.

Mr Cormack: We always look at our programs. We look at how they are travelling. We look at how they are performing in terms of their KPIs. We take advice from a range of different sources such as headspace, PHN and others. So we are always looking at making sure that our programs are best allocated according to need. But there is not a fixed, precise formulaic approach to doing that in every instance. We take advice from a number of sources.

Senator O'NEILL: So some work has been undertaken, and need will be a consideration?

Mr Cormack: Yes, indeed, and we will continue to do that as we assist the government in forming its decision, which is yet to be taken.

Senator O'NEILL: Are the locations of the sites identified yet?

Mr Cormack: We are in the process of looking at need. I think I will just continue to repeat the answers I have given.

Senator O'NEILL: So the locations are not yet determined?

Mr Cormack: No, they are not yet determined.

Senator O'NEILL: When the Prime Minister announced a commitment to fund these 10 extra headspace centres, were you involved in the calculation of the $20 million funding package?

Mr Bowles: It was a government commitment, I think, during the election period, which we do not get involved in.

Senator O'NEILL: Had you given any advice to government prior to the election about the quantum of money that might be needed in this space?

Mr Bowles: Not specifically in that space.

Senator O'NEILL: I am just trying to understand. You said that you are constantly undertaking review and assessing need. Are you saying that, before they went to the election, the government did not have a needs assessment that said, 'You need 10 more headspace centres, and it will cost $20 million'? You had not provided them with any?

Mr Bowles: We had not provided the specific advice that you are asking for just prior to the election, if that is the answer you are looking for. Neither did we provide it after the election being called. We are now in the process of providing advice, having heard what the government's commitment is, and we will now translate that into detailed advice to enable them to implement their election commitments.

Senator SIEWERT: I have got a lot of questions that I will put on notice in the interests of time. I do want to check, though, that we will be able to address Aboriginal mental health on Friday. That is still the plan? Yes? Okay. Can I ask a few questions around mental health nursing services. That is another funding program that went into the PHNs. I have been told that, with it going in, some of the funding has been reduced—for example, in Victoria—into supporting mental health nurses. Do you know if that is correct?

Ms Cole: The MHNIP program was a demand driven program, so that meant that applicants put in applications for a certain number of sessions and so forth each year. When it went into the PHN program it went in on a population distribution basis amongst the 31 PHNs. Because it had been demand driven in the past, there was a fair degree of unevenness around the allocation of those resources versus the population and the availability of other services. For example, Victoria had one of the highest proportions of MHNIP funding compared to its population and much of that funding was concentrated in innercity locations where there are already a great deal of Medicare services for mental health, so there was some redistribution. There was no reduction in funding, but there was a redistribution.

Senator SIEWERT: Do I interpret that to mean that there was a redistribution to other areas, so some areas lost and some gained? Is that what you are saying?

Ms Cole: That is exactly correct, but that redistribution does not happen until next financial year.

Senator SIEWERT: I think there is a great deal of concern in Victoria, for example. Certainly that is the feedback I am getting. Would you direct me to where I can find the detail of the answer you just gave in terms of which PHNs and states got money and what they got?

Ms Cole: I can give you a breakdown by PHNs for that specific program. We do not have it publicly available at the moment.

Senator SIEWERT: I just did not want to put you to extra work if I did not need to. If you could provide that and what the areas got, so I can get an idea of where the funding came from and went to, please.

Ms Cole: Yes.

Senator SIEWERT: I have a series of other questions on that initiative but I will put them on notice. I would like an update though—and you mentioned it, Mr Cormack—on the Fifth National Mental Health Plan.

Mr Cormack: I am happy to do that. I might ask one of my other colleagues to join me for this. Mr Booth has responsibility for progressing the Fifth National Mental Health Plan. I will hand over to Mr Booth in a second. As you are aware, this is not a sole Commonwealth activity; it is a joint Commonwealth-state activity. We have been working very closely with the sector. This has been overseen by AHMAC through the Mental Health, Drug and Alcohol Principal Committee. The Commonwealth has been providing the secretariat work for it. I will ask Mr Booth to give you a more detailed update on where we are up to with the national mental health plan.

Mr Booth: As Mr Cormack said, we are working closely with other states and territories, all jurisdictions, to develop the fifth mental health plan. I will tell you where we are up to at the moment. A writers group was established some time ago and basically has been working across those jurisdictions and also with other bodies to produce a draft consultation document. That draft consultation document is almost ready. We anticipate that it will be made public within the next few weeks. The idea is to go to consultation during October and November to get feedback on that. That consultation process is going to be done together with Mental Health Australia, as the national peak body. It is going to have consultation in all states and territories with members of MHDAPC, who have been involved in the writers group—actually taking part in that—so it can link into state based mental health plans as well.

I can give you an idea of what is in it. It has got seven priority areas within it that will be going out for consultation. The priority areas are: integrated regional planning and service delivery; coordinated treatment and support for people with severe and complex mental illness; safety and quality in mental health care; suicide prevention; Aboriginal and Torres Strait Islander mental health and suicide prevention; physical health of people with mental illness; and stigma and discrimination reduction. Those are the areas that we will be going out to talk to people on. The idea is to get an as substantially finished document as possible by the end of the year and into the beginning of next year and then it will go into the AHMAC CHC process to get signed off. We will be looking at the time frames associated with that.

Senator SIEWERT: Thank you. Chair, in the interests of time, I will now put the rest of my questions on notice.

Senator O'NEILL: I would like, if I can, to go to the early psychosis youth services program that is run by Orygen. You would be aware of media reports around this and concern about funding. Is the department aware of claims that the headspace Youth Early Psychosis Program is currently operating short of funding?

Mr Cormack: We have certainly been made aware of some concerns being expressed by a number of the providers. If I can just give the context of that, in the government's response to the National Mental Health Commission report in November last year the government

committed to a certain course of action. That was, essentially, to regionalise and incorporate the early psychosis youth service model into the core responsibilities of PHNs. The government had made a specific decision. In the context of the election, the government made a new commitment. The new commitment was, essentially, to maintain the existing funding and service model for the six EPPIC centres for three years instead of two, which was the previous decision taken by the government.

Where we are is that we have contracts in place, with the six centres, that are reflective of the decision by government in November, and we are just now in the process—similar to the discussion we just had around the additional 10 headspace centres—of working with government to give formal effect to its election commitment.

Senator O'NEILL: Are there contracts in place or are there contracts in negotiation?

Mr Cormack: There are contracts in place for the six centres that effectively guarantee two years funding on a sliding scale. Once the government gives effect to its election commitment, those contracts will need to be modified to reflect the government's commitment to three years funding instead of two. That is where we are at.

Senator O'NEILL: Have they got the money or not?

Mr Cormack: They have money to operate under the existing service model arrangements and as soon as the policy authority is given to negotiate new contracts—and we are, obviously, working very closely with government to provide them with the advice they need to formalise that—we will be working with the six sites to modify their contracts to reflect the new government election commitments.

Senator O'NEILL: There is a great gap between what you are implying in your answer, here to me, tonight, and what is being reported. It is being reported that the early psychosis program is still $14 million short. Where does the truth lie in this matter?

Mr Bowles: You asked us a question. Mr Cormack has answered the question. We do not know where the media report comes from, in what context it is happening. You have asked us a question. We have answered that question.

Senator O'NEILL: There is a very big gap between what I am hearing and—

Mr Bowles: That might be a gap between what we are saying are the facts in front of us and what the media will report. We cannot respond to every single media report that is out there because, quite frankly, they are far from the truth, in a lot of cases—not all but in a lot of cases.

Senator O'NEILL: If the money that is in question, that is being debated in the public place—and we are talking about funding for Professor McGorry's Orygen units, which are highly regarded. He is Australian of the Year and an advocate for mental health.

Mr Bowles: We do not need to be told what esteem he is held in. We deal with Professor McGorry all the time.

Senator O'NEILL: We do need to deal with the facts: has he got the money or not?

Mr Cormack: Professor McGorry is, clearly, advocating for an early translation of the government election commitment into new contracts. We as public servants are unable to negotiate additional contracts until such time as the government makes the necessary decisions. This is the same with all election commitments. Once the government makes the

formal decision to implement its election policies, then we can reflect that in contracts if we do not have a policy authority to change the contracts. It is not a bureaucratic problem—it is a legal problem. We need to have legal authority to issue new contracts, and we do not have that.

Senator O'NEILL: When do the two years end, then?

Mr Cormack: At the end of next financial year—2016-17 is year one and 2017-18 is year two. The wind-down period would have been complete at the end of 2017-18.

Senator O'NEILL: I am assuming that the three years would end in 2018—

Mr Cormack: In 2018-19. That is the government commitment, as we understand it.

Senator O'NEILL: So the two years end in June 2017 and the three years end—

Mr Cormack: No, the first year is 2016-17, the second year is 2017-18—that is the current contract period—and the third year, for which we do not have legal authority but that there is a government election commitment for, is 2018-19. Once the decision is taken we can modify the contracts.

Mr Bowles: They are procedural issues.

Senator O'NEILL: So what do you say to the claim that first services do not have enough money to run at full capacity?

Mr Cormack: What we are saying to them is that we are all aware of what the government's election commitment is, we are all aware that we are working with the government to implement that so we can make the necessary contract and policy changes. We will work closely with them to ensure as best we can, within the flexibility we have—which is pretty limited—that we will maintain the funding to them, but at this point in time, until there is a formal government decision—and we hope that will be soon—we have to operate within the existing contract parameters.

Senator O'NEILL: The article that I was referring to, that you doubt, was by Ben Pike on 9 October 2016, 'Mentally ill youths left on list', and it states:

Kids are being denied crucial mental health treatment because the federal government has not sealed the deal on an election promise.

Mr Bowles: I do not think anyone said we doubt things—we just do not operate off media stories. We operate off a proper legal base and process within government. We are aware of a whole range of these issues, we are dealing with them, the government has committed to something and we will deliver on that but we will deliver on that within the legal parameters that we have to operate in.

Senator O'NEILL: It reports a meeting between Professor McGorry and Ms Ley, it says 'tomorrow', which would place it on 10 October, and Professor McGorry says that plans were to finalise the issue at that meeting on 10 October. Can you say if that matter was finalised?

Mr Cormack: We were not at that meeting and we are not aware of what—

Senator O'NEILL: Have you been given any action or reaction from the minister following the meeting?

Mr Cormack: Our direction, if you like, is to prepare the necessary advice for government for them to formalise their decision, which is to add an additional year of full

operating capacity to what is currently a two-year contract. Once that decision is taken we will be able to bring effect to that in a contract change and essentially the concerns that are being raised by the PHNs should be addressed.

Senator O'NEILL: So Professor McGorry hoped to finalise this meeting on the 10th, but you are not indicating to me that that has been finalised; you say there still—

Mr Cormack: What I am saying is that Professor McGorry is not the policy authority for the issuing of Commonwealth funds. The Commonwealth government and the cabinet are the decision making authority for new funds, not Professor McGorry.

Senator O'NEILL: Have you had any direction between the 10th and today from Ms Ley?

Mr Cormack: We are operating within the current government commitment to deliver on something. We do not need anything further to do what we are doing. We are working to get to the outcome that you are talking about and Professor McGorry has talked about. We do not need anything further. We have procedural issues that we are working through. We are talking about the third year—

Senator O'NEILL: Have you been advised to hurry up since 10 October? Did the minister's office contact you and ask you to expedite the matter?

Mr Cormack: No—and, again, you are misconstruing what we are saying here. We are talking about the third year, to start with, and we are talking about an issue that is a government commitment. It will be delivered and we are working through the process to deliver it. We cannot say any more.

Senator O'NEILL: I understand what you are saying, but there has been no direction from the government between 10 October, when that meeting occurred, and now.

Mr Bowles: We do not need one. I do not know how many times I can say that. We do not need any more direction. We have the direction. We are working through this issue. We are very clear on what the government's policy position is and what the government's election commitment is, and we will deliver on that.

Senator O'NEILL: When do you expect to deliver on it? What is the closing date for the deal?

Mr Bowles: We will do our bit, but, ultimately, it goes through government process.

Senator O'NEILL: What is your expectation of the timing on that, Mr Bowles?

Mr Bowles: I am not in control of governments—

Senator O'NEILL: No, you are not, but you are bowling it up to them.

Mr Bowles: That is an unfair question. You know how governments operate. They go through good cabinet process. That is what they do.

Senator O'NEILL: We have no date.

Mr Bowles: That is not what I said. I said we have good government process and governance process—that is what is happening.

Senator O'NEILL: And we have a sector with no date, Mr Bowles.

Senator POLLEY: Can we move on to palliative care?

Mr Cormack: Just before you do, can you clarify if you are talking about palliative care in Tasmania or palliative care more generally?

Senator POLLEY: We have to go to MYEFO, but when we come to palliative care, yes, it is Tasmania.

Mr Cormack: That is okay, because we have two parts of the department that deal with palliative care. We have a special part that deals with palliative care in Tasmania.

Senator O'NEILL: I would like to clarify an element of the mental health funding from MYEFO. During the February Senate estimates, it was well established that Mr Cormack stated that $141 million from MYEFO was not going to be reallocated to mental health programs. I want to be clear on this funding, because since the February estimates we have had an election, and in this election the government announced funding of $192 million across the forward estimates. Realistically, one would calculate that if you take $141 million out and not reallocate that funding to mental health programs, then you are technically $141 million down in funding.

Mr Cormack: I do not believe that is the case. For accuracy's sake, I will attempt to clarify that issue for you tonight. I cannot do it on the spot now. I do not believe that is the case.

Senator O'NEILL: So that you can give me a full response, if you have already cut $141 million out of the budget and then you announce $192 million in funding for election commitments, the calculations suggest that only $51 million is being allocated, rather than $192 million.

Mr Cormack: That is simply a different way of asking the same question.

Senator O'NEILL: The reason I am asking is that the election documents do not state if the $192 million is new, additional or existing funding.

Mr Bowles: It is new money. It was an election commitment. It is additional funding. You are now conflating something that happened at MYEFO. Since then, we have had a budget, an election and election commitments, and we are now moving on. You are conflating a whole range of different issues.

Senator SIEWERT: We can add up.

Senator O'NEILL: You might talk about conflating; we just want some clarity around what has gone where and what has been removed. The minister admitted in the parliament last week that the government's mental health commitments were based on 'effectively' new funding. As this goes on, I get more and more confused about the $192 million. During consideration in detail yesterday, Mr Lee stated: 'There is the $192 million that the Prime Minister allocated during the campaign because of his personal passion for suicide prevention.' So, the minister thinks the Prime Minister allocates funding.

Mr Bowles: No, that is an election commitment—we have already said that. The $192 million is an election commitment that the government committed during the election campaign.

Senator O'NEILL: She seems to have struggled to get Treasury and Finance to agree to put money in.

Mr Bowles: No, I do not know what you are talking about there. During the election, the Prime Minister committed $192 million to mental health.

Senator O'NEILL: Who is responsible for the mental health funding allocation? Is it to the minister or the Prime Minister?

Mr Bowles: The Prime Minister seems to sit at the top of what we are talking about here.

Senator O'NEILL: He is making this decision—it is his call. What is the make-up of the $192 million in funding? Could you indicate what is existing, reallocated or additional.

Mr Cormack: Our advice is that this is all new money.

Mr Bowles: There is no reallocation.

Mr Cormack: We are going through the processes—just let me talk you through what they are. The $192 million includes $111.5 million for 10 new headspace centres, funding for 10 PHN lead sites—

Senator O'NEILL: How much for that?

Mr Cormack: I will get that figure for you in a second. There is $46 million to help prevent suicide and reduce suicide behaviour, which includes additional funding for four PHN lead sites conducting suicide prevention trials and funding for a further eight regional lead sites; $32.5 million for e-mental health and other digital health services, including trialling a crisis text message service through Lifeline; and $1.5 million to the Australian College of Mental Health Nurses to look at a workforce model. That is the $192 million.

Senator O'NEILL: And the total of that is $192 million?

Mr Cormack: Yes, I believe so.

Senator O'NEILL: Thank you for putting that on the record, but if you could provide the document that would also be quite helpful.

Mr Bowles: We can provide that on notice.

Senator O'NEILL: Thank you very much, Mr Bowles. Whose decision was it not to reallocate the $141 million funding to mental health programs?

Mr Bowles: We will probably take that on notice. Again, it was MYEFO, so that is three budget decisions ago.

Senator O'NEILL: There was a commitment, by my understanding, by the government to maintain mental health funding in its response to the national mental health written report.

Mr Bowles: Again, I will take it on notice. It was MYEFO, which was around 12 months ago. We have had a budget, we have had an election, we have had election commitments and we have moved into a different phase. I will take it on notice. I understand.

Senator O'NEILL: We have a lot of people who have not moved on and who have continuing mental health problems and challenges that have been well described by my colleagues. They have not moved on, Mr Bowles.

Mr Bowles: Thank you, Senator.

CHAIR: We will move on to great things Tasmanian before we go to Senator Kakoschke-Moore.

Mr Bowles: Chair, are we finished with mental health? Do we want the National Mental Health Commission?

Senator SIEWERT: We were hoping that they were going to come in when the department was here. I will put my questions on notice.

CHAIR: So they can go, Secretary.

Mr Bowles: They can go home?

CHAIR: Yes, you are released.

Mr Bowles: On notice is fine; I just do not want to have people sitting around here.

CHAIR: Senator Polley, for Tasmania.

Senator POLLEY: Yes, all things great about Tasmania. Is there an extension of funding for any elements of the Better Access to Palliative Care program being considered?

Mr Cormack: I will just ask Ms Cole to give you the details. It was $49.2 million that was won of funding provided under the Better Access to Palliative Care program Tasmania.

Ms Cole: That is correct. That expenditure was not completed during the term of the agreement, so there has been an extension to two elements of that funding.

Senator POLLEY: Just to be very clear: there is no consideration of extending any funding under that program?

Mr Cormack: The $49.2 million is the total amount that is available for that program. One of the programs has been extended in time using the existing envelope for $49.2 million. The agreement underpinning that has run its course and there is no additional funding going to Tasmania under that special BAPC program once the $49.2 million is expended.

Senator POLLEY: You started off so well by acknowledging how special Tasmania is.

Mr Cormack: They got $49.2 million more than any other state did, Senator.

Senator POLLEY: They did, and they deserved more. In that case, what is the purpose of the evaluation of the Better Access to Palliative Care program? If the evaluation finds that the BAPC program is delivering great outcomes—which I understand it has done—is there not going to be any consideration by the department or, just as importantly, from the government, Minister Nash?

Mr Cormack: Minister Nash can answer that one.

Senator Nash: Sorry, could you just repeat that for me, Senator Polley?

Senator POLLEY: There was an amount of money that was given to Tasmania in terms of the Better Access to Palliative Care program, which has used its money. It has been evaluated. What I was asking was: if the evaluation comes back—which I expect it will, in all fairness—saying that this program has been successful, is the department considering extending some funding? And if they are not—they keep telling me we have had all we are going to get—is the government going to consider funding this important program to continue?

Senator Nash: I am not aware of the minister's position on that, so I will take it on notice for you.

Mr Cormack: But I can clarify the department's position. That is that we do not have any policy authority to move beyond the existing $49.2 million. The evaluation is a very significant amount of taxpayers' money. It is a special program. There will be a lot of learnings from it. We are keen to ensure that the money has been invested well and has achieved the outcomes and outputs that were expected under that agreement, and, as with any evaluation, that it helps to inform future policy and future considerations on a whole range of fronts. Palliative care is a very important part of our overall policy responsibilities and we are looking forward to getting the results from that evaluation.

Senator POLLEY: Senator Bilyk, who has a vested interest in this area, had to leave, so it would be very remiss of me if I did not ask whether or not the evaluation, which was expected to be completed by September this year, has been completed.

Mr Cormack: It has not been completed yet.

Senator POLLEY: Have you got a time frame for when you expect it to be completed?

Mr Cormack: Yes. It is due for completion by the end of December 2016.

Senator POLLEY: So why is the—

Senator SMITH: So we would be unable to take any decisions about future funding until the evaluation was completed, and the evaluation is going to be completed in December?

Mr Cormack: The evaluation will be completed in December. It is really up to government to determine what it wishes to do in relation to any future commitment.

Senator POLLEY: Just to get some more clarity: why is the BAPC program being evaluated after the national strategy? And is the BAPC evaluation going to be used to inform the national strategy, or is the national strategy set in stone regardless of the outcomes of the BAPC evaluation?

Mr Cormack: There is another group of esteemed colleagues who can talk about the National Palliative Care Strategy. That is another set of officials.

Senator POLLEY: Okay. So, can we go back to Tasmania again so that we are not chopping and changing?

Mr Cormack: We would be happy to go back to Tasmania. What is the question about Tasmania?

Senator POLLEY: Palliative Care Tasmania is close to having to close its doors this year. If the evaluation finds that their community education and advocacy services are delivering good results, would there be any circumstances in which the department would recommend to the government that they continue and extend this funding?

Mr Cormack: That is sort of a hypothetical question.

Senator POLLEY: It is a good one, though.

Mr Cormack: It is a very good one, but it is hypothetical.

CHAIR: Do not be drawn.

Senator POLLEY: I am innocent here.

CHAIR: She is on fire as it is.

Senator POLLEY: I am very innocent.

Mr Cormack: I do not think you are at all, Senator.

Senator POLLEY: I will take that as a compliment.

CHAIR: The rest of the committee concur with you, Deputy Secretary.

Mr Cormack: The evaluation will be a very useful piece of information for the department, and for the government should it turn its mind to further investments in palliative care, or further refinements in its overall policy approach to palliative care, anywhere in Australia, including Tasmania.

Senator POLLEY: That is why Tasmania, I think, was used as a pilot project—because we are outstanding citizens and we do things so well there. Thank you very much for that.

CHAIR: Excellent! Thank you, Senator Polley. I note that Senator Di Natale, Senator Kakoschke-Moore and Senator Rice, who had the next brackets of questions, are not here.

Senator POLLEY: Oh good; we can move on to aged care.

CHAIR: I do not think we really have much choice but to move on to aged care. After that we have nothing for the health workforce section, primary health care quality and coordination section or primary care practice incentives. We have done hospital services and Food Standards Australia and New Zealand and we have already dealt with the NHMRC. That takes us to outcome 6. Thank you, officers, for staying and for your patience.

Ah, Senator Rice has arrived! Secretary, are officers from FSANZ still here?

Mr Bowles: You want FSANZ? Dr Webb has run, so let me just check. Yes, I have been told he is coming back.

CHAIR: Thank you very much, Secretary, for that miracle. We welcome the officers from FSANZ.

Food Standards Australia New Zealand

[20:35]

Senator RICE: Thank you for coming back, Dr Webb. I want to start by asking about conflicts of interest. Do all members of FSANZ expert committees have to declare potential or actual conflicts of interest?

Mr McCutcheon: Yes, it is a requirement for them to declare their interests before they participate in any of our workshops, committees et cetera.

Senator RICE: How are those declarations made? Are they made in writing or recorded in the minutes?

Mr McCutcheon: Generally, they are made in writing, but there have been occasions, for example, with workshops, where we will consult with them before the workshop and basically ascertain whether they have any interests. I should add though that, in most, if not all of the cases, we are talking about experts—people who are experts in their field of science or whatever it might be—so generally, there is a public record of what they are involved in, what research and so on. The exercise that we conduct is really just in addition to what is already available in the public domain.

Senator RICE: I certainly recognise that it can be impossible to avoid conflicts of interest. So it is the declaration of it that is important.

Mr McCutcheon: It is important that we know, but the driver for us engaging with experts to participate in our processes in an advisory capacity is to basically tap into their knowledge and expertise to help us inform our decisions.

Senator RICE: Would you be able to take on notice tabling a list of members of those committees that have declared conflicts of interest?

Mr McCutcheon: Yes, we can certainly table members of our committees. In fact, that is again publicly available information that would appear in our annual report, for example.

Senator RICE: Are there other members that would declare interests that are not members of your—

Mr McCutcheon: Obviously, the FSANZ board itself. There is a declarations of interest register, which again is available on our website. Our senior executive also have to declare interests, so we have that on our records. And, as you have previously noted, the various committees that we have would too.

Senator RICE: Once the conflicts of interest are declared, is there any process to look at the ramifications of that conflict of interest?

Mr McCutcheon: Yes, and I guess there are two answers to that question. For all of our committees, as they are advisory committees only—they do not have any particular decision-making role—you would certainly look at their interests, and our main reason for doing that is to make sure we have the appropriate expertise around the table to provide us with the advice that we are seeking. The second example, the second set, relates to the board. It is the decision-making part of the organisation, and those declarations of interests are basically considered before each meeting and then the board makes a decision on whether that particular member can participate in the discussion and can vote or not vote on those matters.

Senator RICE: On the advisory committees, are there particular ramifications if some conflicts have been declared—that they have not been able to participate, or other consequences of those conflicts of interest?

Mr McCutcheon: There are no consequences per se. We basically rely on the information that they would provide us directly when requested to table their interests, plus information that would be in the public domain. Again, most of these people will come from academia and the like, so that information is readily available.

Senator RICE: Do you do any independent confirmation of those conflicts of interest?

Mr McCutcheon: Our staff would check, but, to be quite honest, a lot of that checking would be done before we approach them, because we want to know what particular skills they are going to bring to our committees to be able to inform our processes.

Senator RICE: Moving on to nanomaterials, it is my understanding that manufactured nanomaterials are being used in foods sold in Australia. Would FSANZ agree that nanomaterials, if they are intentionally manufactured and used, are being used in preference to the same materials of larger sizes because of their functionality?

Mr McCutcheon: That is an interesting question. I will use food additives as an example. There are lots of products where the manufacturing process for incorporating food additives into food products does produce materials in the nanoscale size. That has been going on for a long time, and that would not necessarily require any regulation per se. Where there is a

requirement is where manufacturers are deliberately using nanotechnology to change the behaviour of those particular nanoparticles in the manufacturing process. There is a requirement set out in our application handbook for them to make an application to FSANZ.

Senator RICE: If the use of the nanomaterial is for functional purposes, does FSANZ consider the material to be a novel food and subject to premarket safety assessment?

Mr McCutcheon: Again, the handbook is very specific around the requirements for manufacturers to inform FSANZ and make an application if the size of the particle that they are seeking to put into the food product does have some different behaviours or novel characteristics. So in that sense it would require an application.

Senator RICE: So you would require it then?

Mr McCutcheon: Yes, that is basically how it is set out in the application handbook.

Senator RICE: So why hasn't FSANZ referred the question as to whether nano-ingredients in food constitute a novel food to its Advisory Committee on Novel Foods?

Mr McCutcheon: Again, it would depend on the particular food product, but we rely on the information that we would get from companies and other sources that would indicate that that product had some novel characteristics. At the end of the day, the decision by an individual company on whether it wants to inform FSANZ and make an application is a decision for that company. The way food regulation operates in Australia, the actual law itself is applied at a state and territory level, and so there is an obligation on all of the food manufacturers to produce safe and suitable food. If they do not, as a result of the manufacturing processes, including the potential application of nanotechnology, then they would be certainly in breach of law and also in breach of the requirements of our application handbook.

Senator RICE: Have nanomaterials been referred to the novel foods advisory committee?

Mr McCutcheon: I would have to take that question on notice. I can certainly say that we have not received any applications for nanotechnology or nanomaterials.

Senator RICE: Although you do consider them a novel food. But you have not received any applications?

Mr McCutcheon: We have not received any applications.

Senator RICE: But you know that there are nanomaterials that are being used in food in Australia?

Mr McCutcheon: When you say used, again the manufacturing process—the example I used was food additives—does produce materials that are in nano form. That has been happening forever and a day. It is where they actually intentionally apply nanotechnology to those particles to produce a particular outcome where they would be required to make an application.

Senator RICE: In a document released under freedom of information in July this year, FSANZ notes its view to a manufacturer that nanoparticles that dissolve in the water or lipid phases of the food to which they are added or in the gastrointestinal tract will not be considered nanoparticles for the purposes of regulation. Is it correct that this view of what constitutes a nanoparticle for the purpose of regulation under novel food provisions is FSANZ's definition of it?

Mr McCutcheon: No, it is not a definition. We have conversations with industry, with companies and with members of the public on a daily basis on potentially submitting an application. That advice would be on the basis of the information they provided us and our preliminary assessment within the organisation at a low scientific or technical level. The absolute decision-making process on that particular case would not happen until it got to the FSANZ board.

Senator RICE: I am told that that definition or not definition was proposed in proposal P1024.

Mr McCutcheon: Proposal P1024 relates to a review of the regulation of nutritive substances and novel foods. So for that proposal—even though it has been on our books for a number of years now—there is still a fair way to go in terms of how we deal with novel foods through the Food Standards Code. I must say that this has been a challenge for 20-odd years, trying to come up with the right regulatory formula for that; but nonetheless, as I said, the final decision on those sorts of matters would not happen until an application was put to FSANZ and was considered by the FSANZ board.

Senator RICE: So effectively that is not a formal definition?

Mr McCutcheon: No, it is not. I would make the point that companies or individuals that would seek advice from FSANZ will go back and basically make a commercial decision on whether they want to put in an application or whether they want to sell their food onto the market in the form that they propose. If it were considered to be by one of the state or territory regulators to be in breach of the Food Standards Code, then they would be subject to action by that particular jurisdiction.

Senator RICE: Is there any legal restriction on FSANZ considering the question of labelling of nanomaterials without an application being submitted?

Mr McCutcheon: There is no legal restriction. Anyone can make an application to amend the Food Standards Code.

Senator RICE: Could FSANZ take action itself?

Mr McCutcheon: FSANZ could take action itself through the proposal process, but that is not something that we are contemplating.

Senator RICE: I will put more questions on notice.

CHAIR: Thank you, Mr McCutcheon and Dr Webb.

Senator DI NATALE: Are you able to answer questions on Heath Care Homes in the health portfolio?

Mr Bowles: Fire away. We might have some people on that.

Senator DI NATALE: I want to put on the record that I think it is a positive initiative. It is really the funding that concerns me. Can you confirm that basically that this equates to less than $150 in incremental investment, on average, per patient? Is that the quantum we are talking about?

Mr Bowles: Let's take a step back. Health Care Homes is in a phase where we are looking at a patient group of 65,000 across 200 practices, as you have heard before. It is around looking at a new model of care and funding. It is not about increasing funding per se; it is about trying to understand how to get better health outcomes for a particular group of patients.

We are using that 65,000 and 200 practices to get this right before we really start to look at how this really rolls out in a bigger context.

The idea here is to get better patient outcomes for people with chronic and complex conditions. That is what it is about. It is not about giving additional money. We have some additional money to run this project and to look at how we stratify payments and we tier payments under a new clinical model and a new funding model. But in that context we are not there yet. This is the process we are in the middle of right now.

Mr Cormack: The funding that is available for this program is approximately $21 million for supportive infrastructure for the program. That covers the payment system—

Senator DI NATALE: Is that additional funding?

Mr Cormack: Yes.

Senator DI NATALE: That is not money redirected from existing payments—

Mr Cormack: That is project infrastructure funding. Separate to that here is $93 million which is effectively redirected from the MBS for clinical services. That will be repackaged into effectively a risk-adjusted, capitation payment to the treating clinician or practice, which enables the new model of care to be implemented, tested and evaluated.

Senator DI NATALE: Do you have details of what those new payments look like?

Mr Cormack: We are just working those up at the moment. I might ask Mr Booth to give a bit of a progress report on how we going with that.

Mr Booth: As you know, the PHCAG report recommended a three-tier approach, whereby you have the most complex patients in the top tier. In the middle tier you have those patients who are at risk of hospitalisation, then in the bottom tier you have those patients who could essentially look after themselves but needed to have some kind of care pathways put around them. They recommended that there should be different levels of payment for each of those tiers, obviously with a high level of payment at the top and a lower level payment at the bottom.

We have been doing a considerable amount of work on that and looking at what those payment levels should be. They are still being worked out at the moment, but in order to try and test them in a real-life situation, we are working with a couple of practices in different parts of the country in terms of trying to stratify some patients and putting those funding amounts through an actual practice to see what happens. That work is actually going on as we speak. We should have the results in time for the expression of interest process, to feed into that area.

Senator DI NATALE: Do you plan to link those bundled payments to patient outcomes over time?

Mr Cormack: Yes. Depending on whether you divide the payment into quarterly payments or whatever, it will be triggered by a specific milestone or a specific deliverable. The team are just working on defining them.

Senator DI NATALE: Are you going to make this public? When will you make public the modelling and what the structure looks like? At what point will we get an estimate?

Mr Cormack: There is a communication strategy that goes with this that will explain where we are up to. Obviously the payments that we work through with the treating practices will not be secret. As soon as they are sorted out we will make that—

Senator DI NATALE: Do you have a time line?

Mr Cormack: We have very tight time line. This enrolment needs to start next year and we need to be able to start the payments moving out from the beginning of the 2017-18 financial year. So we are moving pretty quickly.

Senator DI NATALE: Will the payments be indexed?

Mr Cormack: We have to work through that. These are not like MBS fee-for-service payments. I do not think we want to entertain another debate about an indexation arrangement, I would suggest.

Senator DI NATALE: So they are likely to be indexed?

Mr Cormack: I am not saying that at all. I am saying that we have yet to work out a payment arrangement and we are not saying they are like an MBS payment or a PIP. They are something different.

Mr Booth: To be clear, we are not going there. We are not going to enter into a conversation about whether they are indexed or not at this particular point.

Senator DI NATALE: So they may not be indexed?

Mr Booth: We are not going to enter into a conversation about that.

Senator DI NATALE: Have you made a decision?

Mr Booth: No, we have not made a decision. We are trying to work out what is the most effective payment mechanism, as Mr Cormack said.

Senator DI NATALE: It is a trial, and obviously the aim is to get GPs interested and participating. Obviously, if you say to them they are going to get less money in year 2 than in year 1, that is going to make it a little harder, isn't it?

Mr Booth: That is a hypothetical question, is not it?

Senator DI NATALE: Indeed it is hypothetical. Unfortunately the indexation of MBS payments is not hypothetical, but that is another story.

Mr Cormack: That is right.

Senator DI NATALE: How did you select the 200 trial sites?

Mr Cormack: We have not selected them. We have selected 10 regions.

Senator DI NATALE: So they have not been selected yet. How are they being selected?

Mr Cormack: There will be an expression of interest process. We have identified 10 geographical regions and in the fullness of time, not too far off, we will call for expressions of interest from practices in those regions.

Senator DI NATALE: On what basis do you select them?

Mr Cormack: Obviously their keenness to do the work; that they are likely to be able to enrol patients that meet the criteria; geographical spread—we are obviously looking at different demographic groups—we are keen to get rural, outer metropolitan and some specific Indigenous elements to it.

Senator DI NATALE: What role of the primary health networks playing in all of that?

Mr Cormack: A very strong role. These operate within 10 primary health care regions. So we would be looking to them to be an integrator of services. They will be looking to integrate—

Senator DI NATALE: In terms of selection of practices?

Mr Cormack: We have not really got down to the detail of how that is going to be worked through. In fact, we have a session with the PHNs tomorrow to have a bit of a deep dive into some of those things.

Senator DI NATALE: Do you expect they will be pretty integral to the selection process?

Mr Cormack: Absolutely. They will be very integral to the whole program.

Senator DI NATALE: Obviously they have to be. I am talking specifically about selecting the practices. Is the department planning on doing this on their own?

Mr Cormack: Not at all. This is a partnership, and we will be very much looking to the PHNs to be very key players in this. They know their practices better than we do, and we will be looking to maximise their understanding of their practices and patient groups in their area. We will be spending most of tomorrow talking through matters PHN—five hours, in fact.

Senator DI NATALE: A lot of the feedback has been that conceptually, people like the idea. It is a good reform, and I said to the department that the government is to be congratulated for taking this on. It is a big step. But a lot of the commentary centres around the lack of funding and the potential of a good idea to go down in flames because it is not receiving the support that it needs to get off the ground. How do you respond to that pretty widespread commentary?

Mr Bowles: I do not accept it at this particular point. That is why we are doing what we are doing with trialling the practices and why we are going to go out with 65,000 patients and 200 practices. We want to get this right and we want to get it right around this smaller group before we go to a bigger group. This should not be about just adding more cost or money to the system. This should be about better clinical outcomes and better payment structures that will help deliver those clinical outcomes. That is what this is all about. It cannot be just about more money in a particular space. We will use this opportunity to test with the sites and the practices. Is this appropriate? Is this going to work? Does this funding envelope that we have look like it actually meets the requirement? Our assessment at this stage is that it would have to be pretty close, but we do not want to be definitive yet, until we get to that point in time.

Senator DI NATALE: How do you plan to evaluate it? What is the process for the evaluation?

Mr Cormack: We will be approaching a panel of professional evaluation companies and there will be a full-blown evaluation of all elements of the program.

Senator DI NATALE: So you will go out to market on that?

Mr Cormack: Yes.

Senator DI NATALE: Is that going to be done after the two years? Or will it be ongoing?

Mr Cormack: They will be coming on board right at the beginning and all the way through.

Senator DI NATALE: Good. I suppose the concern is that this is a reform where you would expect many of the benefits to take some time to come into effect, beyond the two years. Obviously an evaluation is not going to pick that up if it is done within the two-year trial. How do you deal with that issue?

Mr Cormack: We will be looking to ensure that the evaluation is a rolling evaluation of all elements of the program. We do not think we will necessarily have to wait until the end of the two years to fully make the case. I think we will be progressively identifying achievements, risks and areas of adjustment all the way through. We are conscious that two years is a tight time frame, but the evidence is pretty strong that good-quality coordinated care associated with changed payment arrangements with a Health Care Home model and a good risk adjustment and risk stratification process are the key elements to making this work. That is what the literature is saying. I guess we are basing this program on what the literature is telling us and, indeed, what the doctors, health professionals and economists are telling us.

Senator DI NATALE: How does it relate to the integrated and coordinated care models that are being funded by the states? What is the relationship?

Mr Cormack: Most of the states have made very big investments in this space and we are looking to partner with state-funded services. That is a lot of the work that is going on at the moment. Every state has come forward with some sort of proposal. We are very much encouraging them to help us to identify the patients and to get involved in the care coordination, the care model, but also to tip money into the risk pool.

Senator DI NATALE: What does that mean?

Mr Cormack: Basically it means that, for example, public hospitals carry a financial risk associated with patients who are poorly looked after, and that turns into the national efficient price—$5½ thousand per adjusted separation. If they are able to prevent an admission that otherwise would have occurred through poor quality primary care, then that is $5,500 they do not have to spend.

Senator DI NATALE: I get that. That is the whole point. What is the risk pool?

Mr Cormack: There is a pool of funding that is effectively available by view of the capitation payment. We would envisage that in some of these PHN regions, the hospitals and, indeed, potentially some private health insurers might be able to contribute additional funding to put together a better package of coordinated care. They all get the benefit of reducing avoidable admissions.

CHAIR: We are planning to break now. The committee intended to move on to aged care after this break. I do not know whether you would wish to place the rest of your questions on notice to assist with timing.

Senator DI NATALE: I would like to ask one more question on the training component.

CHAIR: Very briefly.

Senator DI NATALE: It is probably easiest if I put the rest on notice.

CHAIR: Excellent. Before we have a break, I have just had an indication from Senator Polley that the opposition are happy to put all of their questions relating to outcome 1 on notice. Senator Di Natale, I note you have questions relating to digital health. Do you wish to still ask them after we deal with aged care or are you happy to put them on notice as well?

Senator DI NATALE: In the interests of everyone's sanity, I will put them on notice. That is fine.

Proceedings suspended from 21:02 to 21:07

CHAIR: We will commence examination of outcome 6, ageing and aged care. Senator Polley will open the batting.

Senator POLLEY: Measures in the 2015-16 MYEFO delivered cuts. I just want to check my figures. It was $472 million to the aged-care funding instrument over the forward estimates, and measures in the 2016-17 budget deliver cuts of $1.2 billion. Are those figures correct?

Dr McCarthy: The figures you refer to are correct, but of course the combined effect of those measures was an upward estimates variation of $3.8 billion and a savings measure of $2 billion, so, the effect of those measures was not to cut the aged-care budget but to increase it significantly over the forward estimates.

Senator POLLEY: We will not debate terminology tonight, but the figures that I quoted are correct. We have established that.

Mr Bowles: But you are quoting one side of the picture. That is what Dr McCarthy was stating.

Senator POLLEY: She has put that on record. I understand your role here. You have this opportunity.

Mr Bowles: It is a reduction in growth. That is probably the best way of describing it. The aged-care budget more broadly is growing at about seven per cent. The residential side grows at about five per cent, even after the adjustments around the ACFI changes that Senator Polley was talking about.

Senator POLLEY: In response to the concerns that have been raised by consumers, the sector, the opposition and others regarding the way these cuts were delivered, Assistant Minister Wyatt said that the department would consult with the industry around alternative measures to achieve the government's more than $2 billion cuts. Is that correct?

Dr McCarthy: I think Minister Wyatt would have referred to the department consulting with the sector to find alternative ways of delivering the save, the reduction in unplanned growth, but, yes, it is true that we are consulting with the sector.

Senator POLLEY: Are you in the process of consulting, or has that been concluded?

Dr McCarthy: We are in that process.

Senator POLLEY: Can you tell us what alternative opinions you have been provided with by the Aged Care Sector Committee, by the ACFI Expenditure Working Group or anyone else?

Dr McCarthy: Those consultations are confidential.

Senator POLLEY: So you are not able to give us any information about what other alternative options the government had?

Dr McCarthy: They are confidential.

Senator POLLEY: When will the sector and the community be advised of the government's decision regarding these cuts and any alternative measures that will be adopted?

Dr McCarthy: That would be a matter for government.

Mr Bowles: Just to get it on the record once again—not cuts; a reduction in unplanned growth. Just to get that on the record.

Senator POLLEY: I understand your role, Secretary, and—

Mr Bowles: No, that is the truth of the matter.

Senator POLLEY: That is your evidence, and that is on the record. The consumers and the sector see things differently. I will respect your position; you respect mine for the way that I am able to express the concerns.

In less than six months, the MYEFO measures were determined by your own modelling. Both the assistant minister and the minister, as recently as Sunday week ago on the Gold Coast, said that she wanted to be open, transparent and honest with the community. Can you now release the modelling that the government based their decision on, based on the advice that you gave them?

Dr McCarthy: We have shared with the sector, on a confidential basis, the parameters that were used in modelling those saves. To release the full modelling would go to budget-in-confidence information. Again, we have consulted with the sector and we have explained to them the parameters that were used.

Senator POLLEY: You have provided it to the sector, you are saying, and it is confidential. Even when it was sought through freedom of information, there was no information given to us. If, as the minister and the government say, we need to work together to deliver the best outcomes for older Australians and those most vulnerable, why is the department still refusing to give this committee that information about the modelling so we can actually understand how you arrived at the decision that you did, which led to your advice to the government?

Dr McCarthy: We have had extensive discussions with sector representatives and been very open with them about the parameters that we have used. But that is not the only focus of our discussion. In fact, I think the focus of our discussion has been less on the modelling and more on the alternatives that might or might not be available to reach the same amount of saving. Looking ahead, I think we want to work with the sector very closely, and put our energy into looking at alternatives to the instrument itself, which, everyone agrees, in its current form does not deliver the stability needed for the sector and for the government in financial sustainability.

Senator POLLEY: For us to have a full understanding of the decision that was made—this is not the first time that decisions have had to be made because of costs—it would be so beneficial for us to have that information, so that we can have a better understanding and so we can help move forward. Is there nothing you can provide to us here today that will give us a better understanding?

Dr Hartland: We are happy to take on notice the question about the parameters that we shared with the sector. I do not have them with me at the moment, but we provided a paper to the sector and we will come back to you on that.

Senator SIEWERT: You came to estimates knowing full well that we would ask this and you did not bring a copy of the parameters with you that you gave to the sector?

Dr McCarthy: I think that I have already complained that those conversations with were confidential.

Senator SIEWERT: It was obvious we would be asking for them.

Dr Hartland: I can give you some information about the output of the model, if you wish. It is the output of the model that drives the forward estimates, so what we can give you today is the estimate of the basic subsidy rates underpinning the forward estimates amounts, which may well be helpful, if you wish.

Senator POLLEY: But you do understand that the sector itself—and if you have already provided them with this confidential information—are saying that the effects are going to be up to three times worse than what you are actually admitting to now. So there is real concern still within the sector.

Dr Hartland: We understand that. We have had extensive discussions with the sector about our parameters and we have looked at the modelling they have done to consider whether it sheds any light on us.

Senator POLLEY: And does it?

Dr Hartland: We have looked at that their model and we remain convinced that our estimates are an accurate estimate of the effect of the measures.

Senator POLLEY: Do you understand why not only is there sector frustrated by the attitude that you would know better than those people who are actually providing the services in residential homes.

Mr Bowles: I do not think that is a fair characterisation. The sector are working with us on this issue now.

Senator POLLEY: We are trying to work with the government on this issue as well but we are not able to get the information. Obviously, you have already given some of it, and I think, as Senator Siewert said, you would have known coming to these estimates—let's be fair dinkum: I tried to ask these questions this morning so you have had at least all day, if you had not thought before that that we were going to be asking questions about ACFI funding and the models.

Senator Nash: Let's be fair dinkum, and I think it very important that we have on the record that Labor has banked this saving for the ACFI measure in your election costings. The Labor Party has actually—

Senator POLLEY: But we are not actually in—

CHAIR: Order! Allow the minister to finish.

Senator Nash: Shayne Neumann has actually said Labor is not in a position to reverse those cuts.

Senator POLLEY: But we are not actually in government.

CHAIR: Order!

Senator Nash: You need to be very clear, Senator: you have already banked this save as the Labor Party.

Senator POLLEY: You are in government.

CHAIR: Senator Polley, do you have further questions?

Senator POLLEY: We are here to ask questions about the government's policies. You have actually announced a policy that is going to affect the most vulnerable Australians in this country and you are stonewalling and not allowing the release of the modelling on which your government has based their decision—

Senator Nash: You need to be fair—

CHAIR: Do you have a question, Senator Polley?

Senator Nash: about what the Labor Party is going to do.

Senator POLLEY: We are not in government yet; you are. You are going to have to address these issues so what are you going to do

Senator Nash: You cannot walk away from the fact that the Labor Party has banked the save.

Senator POLLEY: What are you going to do? My question is to the department and to the minister: what are you going to do to restore the faith of the sector—

Mr Bowles: We are working with the sector at the moment around these issues to clarify our position, their position and see if there are alternative positions. We have been working quite effectively with them. As you rightly point out, Senator, this is not the first time. It happened in 2012 as well.

Senator POLLEY: That is right, and we know that; we admit that.

Mr Bowles: The same sort of process , the same sort of deal.

Senator POLLEY: It does not matter which government; these are serious issues. It would not matter who was in government. As it was in 2012, those decisions had to be made. What we have found this time is that we have not been able to see the modelling on which you have based your assessment. Can I ask: who were the sector representatives that you have consulted with—before and now?

Dr Hartland: Thank you. While we find our list of people, we have had four formal meetings with subgroups under the Aged Care Sector Committee. We met with the Aged Care Sector Committee on 23 September. We had a combined meeting of the Aged Care Sector Committee and an expert working group on 17 August, 2 September and 16 September. In addition, I have met with the guild, who commissioned some analysis at least twice, and I have met separately with LASA members.

Senator SIEWERT: Sorry, Dr Hartland—who was that?

Dr Hartland: The guild. It is a peak organisation for larger providers.

Senator SIEWERT: Sorry, I just did not hear you.

Dr Hartland: For the people who attended the ACFI expenditure working group, if you are happy for me to read them into *Hansard*, I am happy to do that now.

Senator POLLEY: That would be great, because—

Senator SIEWERT: If you have a list, you could table it.

Senator POLLEY: If you could table the list, that would save us some time.

Dr Hartland: We can certainly table the list of people who are both on the sector committee and attended those meetings.

Senator SIEWERT: That would be good. Thank you.

Senator POLLEY: That would be great, because what we hearing—what the sector is telling us—is that they are very frustrated that they are not actually getting the information from the government, that there has been lack of consultation.

Dr Hartland: No, I don't think—look, I certainly understand that. We have met with them a number of times and, of course, in the nature of those conversations they have expressed to us a desire for a greater amount of information. We have produced a paper that included the highly unusual step of having some budget-in-confidence material in it. It is not something we would normally do, but Minister White had made a commitment to the sector to share a parameters paper, so we prepared that. The reason why I do not have it with me today is that it does contain information that could be used to derive budget parameters that are not for me to give—they are Treasury parameters. We are happy to take it on notice, but we do have to take it on notice and check what we are able to provide to you.

We felt, after those discussions—and, as I said, we had at least four formal meetings and at least three other meetings with people about those parameters—that we had kept faith with Minister White's commitment to share information about the modelling. I do not think, from my discussions now with the sector, that that is an issue for those people who attended. But, obviously, we did not speak to everybody in the sector.

Senator SIEWERT: Could you explain that a little bit more in terms of 'not an issue'? Do you mean the whole thing is not an issue anymore, or the understanding of the basis—

Dr Hartland: The parameters issue. Senator Polley raised with us what she had heard, which is the angst in people wanting to understand the department's parameters, and I understand that issue. We have talked with them, as I said, on a number of occasions with this paper. Post that, we are not having from the people in those conversations the same degree of agitation about how the modelling was done, how it was derived. I think it is fair to say, as I said to you before, that we had reviewed the alternative models that had been done and looked at how they derived their figures. I said to you before that that did not lead us to change our view. Some of the people in those meetings were the authors of the alternative models and I think that, in fairness, it is also true to say that they looked at our parameters and have resolved not to change their view.

Senator SIEWERT: So it was an agreement, to a degree?

Dr Hartland: There is models at 30 paces, if you like. Having said that, I do not detect from the people I talk to—but I do not talk to everyone in the sector—that there is a great desire to continue the conversation about modelling. As Dr McCarthy points out, now the balance of the conversation is moving towards: are there alternatives that the sector will find preferable to the approach that was expressed in the budget measure, and what are the risks and possibilities of those alternatives.

Senator SIEWERT: Do I take from that that you are saying that there is an acceptance by the sector that cuts need to be made, it is just about where they are made?

Dr Hartland: No, no. I think we need to be really fair to the sector on this. We have made a commitment to them that we would use, sort of, the classic Chatham House Rules thing, that we will not reveal—we made a commitment that we would keep the conversations private, although we would indicate what the nature of the conversations have been to our minister,

except where they want it to be identified. They have, of course, as you might imagine, all been keen to tell us and to make sure that we relayed that, by their participation in discussing alternatives, they were not thereby endorsing the need for a budget measure. And I think that is—

Dr McCarthy: I think it is fair to say that they accept that both ministers have been very clear that the savings total must be achieved.

Senator SIEWERT: But they are not happy with it at all?

Dr McCarthy: I do not know of any sector that is ever happy with reductions in growth.

Mr Bowles: And let's be clear and get this back on the record, or still on the record: after these reductions in growth, the residential aged care sector is still growing at 5.1 per cent per annum over the forward estimates, which is faster than PBS, MBS and a range of other things that we deal with. I just want to make that point, because there is still significant growth in this sector, and a large part of it is of an unplanned nature.

Senator POLLEY: Or an ageing population. I want to clarify something. I do not understand why the consultations that you are having with the sector are confidential and why the modelling is confidential. That raises suspicion, both of people in the sector and from my point of view. What don't you want us to know?

Dr McCarthy: I do not sense that the people we are consulting with are suspicious of us. Dr Hartland has explained that the modelling itself contains budget-in-confidence information; even the parameters, which are a subset, contain information that could go to budget-in-confidence material; and, of course, the consultations on the alternative go to issues that potentially are going before government.

Senator POLLEY: But you could have taken out those things that go to the budget and that you believe we should not have knowledge of. That could have been done.

Dr Hartland: It would have been a much shorter paper. It was hard to describe how the modelling worked and how we derived the numbers that are presented in the estimates for the portfolio without indicating some parameters that can be used to derive indexation rates, which, as you might know from your experience in other committees, are not something that a line agency can give away. They are actually Treasury owned parameters. That is why we have been very careful about what we can reveal now.

Senator POLLEY: I am mindful of time. I do not think I am going to get anything else, so I shall move on and surrender.

Senator SIEWERT: Senator Polley, are you still doing ACFI?

Senator POLLEY: Yes, I am still doing ACFI. Dr Hartland, I want to know whether or not the government or the department has done any modelling of the impact of these cuts on rural and regional aged-care services, which, as you would agree, are usually more expensive and come at a higher cost with a lower return. Has there been any modelling done on the impact?

Dr Hartland: Our advice to the minister, both in the development of the budget measures and as we have monitored them, always goes to the distributional impacts, including on rural and remote areas.

Dr McCarthy: You will be aware that, in the budget, there was another measure involving an increase of about $102.3 million in the viability supplement, which assists rural and remote aged-care service providers. At the same time, there were some changes to the way that it is calculated geographically to bring it more up to date. The increase to the viability supplement recognises the difficulties, as you point out, that some rural and regional providers can encounter.

Senator POLLEY: Is there any information you can provide that demonstrates that the modelling had taken into account state-by-state considerations around providing services or a consideration of the not-for-profit services versus those who are for profit? Was there anything in the modelling that you can share with us?

Dr McCarthy: On the type of service—for profit or not for profit—we know from the Aged Care Financing Authority that in every quartile of profitability there are different kinds of services. There are for-profit and not-for-profit services in the highest quartile of profitability and for-profit and not-for-profit services in the lowest quartile. I am not sure that modelling in terms of not-for-profit and for-profit services is necessarily instructive.

Senator POLLEY: There was no consideration of state-by-state issues? There are those like Western Australia who have lots of challenges with remote areas, as does Queensland. There is also the rural and regional nature of Tasmania.

Dr Hartland: I think it is fair to say that, whenever we do a measure, we look at a range of impacts to understand risks and possible effects. We did not look at the type of state issues that you are identifying in the development of this measure.

Senator POLLEY: I take it from that Tasmania is not going to get any special treatment?

Dr Hartland: The modelling was national modelling. The issue is the appropriate estimate of the budget change on the national expenditure. In that measure there were not included special alternative treatments. It operates nationally in the same way depending on the nature of the service. There were no particular deals for particular states.

Senator POLLEY: Do we have any idea about the timing of this consultation and when any alternatives will go to the minister?

Dr McCarthy: We are working out those alternatives and would be expecting to provide advice in the near future, but as to exact timing I am not able to specify.

Senator POLLEY: At the last estimates I found out that for 'the near future' some announcements were made the very next day. Could we say that you are going to have consultations and the alternative options available to the minister by the end of the year?

Dr McCarthy: I would certainly expect to provide advice before the end of the year. There certainly will not be any announcements tomorrow.

Senator POLLEY: That is always good to know. What would your expectation be—I know what the secretary is going to say anyway, but I will ask it—once you have put those recommendations to the minister? How long would it be, knowing that this is such an important and huge issue, before the minister would actually make a decision?

Mr Bowles: It is a decision for government, in all fairness to us. We will provide advice in due course—

Senator POLLEY: But you would press the urgency of the issue?

Mr Bowles: Yes, we always press the urgency whether it is high, medium or low on whatever we are talking about. Ultimately, government has its process, and it will go through its process.

Senator POLLEY: To confirm, the department has not provided options or recommendations to the minister as yet?

Dr McCarthy: Not yet.

Senator POLLEY: We hope to do them by Christmas 2016. I will let Senator Siewert ask some questions on ACFI while I just check my running order.

CHAIR: Yes, and then we will go to Senator Smith as he also has questions on this.

Senator SIEWERT: I just wanted to go back to the issue of the modelling. I will not traverse what Senator Polley has just gone through—I do not agree with your answers but accept they are not going to change. Was the modelling that you did focused on the impact on the budget?

Dr Hartland: That is right.

Senator SIEWERT: Did it include the specific impact on residents in aged care who are receiving the supports that are currently funded by those measures in that particular part of the instrument?

Dr Hartland: We clarify what precisely would change under the measure, and then we analyse the impact of that on ACFI claims from providers. Providers use the tool to make claims for funding, and we seek to estimate the impact of those changes on the claims and therefore the funding that goes from the government to providers. If you mean impact on an individual as to what they receive from the provider, that is a separate matter. In some areas the tool is very specific about particular services, and in some areas it provides more general funding. But either way, the effect of the funding system for aged care is that an amount of money goes from the government to the provider, and then the provider provides a range of services to individuals, so—

Senator SIEWERT: But each individual is assessed against the instrument in order to claim that funding in the first place.

Dr Hartland: That is right. And then the care that is provided gets expressed in a care plan, which is separate and distinct to the actual funding determination arising out of the tool. We are not in between the money going to the service provider and the service going to the person. So our system does not involve us making decisions about the actual care that a person gets; that is the responsibility of the provider.

Senator SIEWERT: Yes, but they provide the care on the basis of the funding they receive. So if their funding for particular items under the instrument is cut—presuming that they are provided with a level of care that matches the funding they get—if you cut that, obviously that is going to impact on a resident.

Mr Murray: Again, the overall funding is growing though, over the forward estimates. In—

Senator SIEWERT: Yes, and so is the number of people going into aged care.

Mr Murray: The funding is still growing.

Dr McCarthy: It might help to go back a little bit and explain that, through any of the analysis of the data, we could not find a connection between what was a sudden and sharp increase in expenditure, in relation to one part of the ACFI, and the natural increase in frailty of residents over time that is already factored into our forward estimates. The measure is designed to ensure that the highest level of funding goes to those residents who need it most. And, as we have explained in other sessions of this committee, the instrument does contain ambiguities—

Senator SIEWERT: I do want to come back to the instrument itself.

Dr Hartland: I do not actually want to necessarily go over the ground of reduction in growth, but it might be helpful for us to tell you what we expect to spend—if you accept that our estimates are sound, which is—

Senator SIEWERT: That is a bold assumption! But go on.

Dr Hartland: That is another question, of course. At the moment, in 15-16 we expected to spend on average under the ACFI around about $59,900 per person per annum.

Senator SIEWERT: That is the average.

Dr Hartland: That is what the claims will amount to on average per FTE. In 16-17, we expect to spend around $61,600. In 17-18, we expect to spend around $63,300; in 18-19, $64,969; and in 19-20, $66,594. Senator, you have been pointing out the 5.1 figure. Obviously, people are ageing and the population is getting bigger, that is true—

Senator SIEWERT: And inflation.

Dr Hartland: Those are per-person figures. We are projecting, post- all of the budget measures, that there will be steady increases in the per-person funding going to providers under the ACFI. On that basis we would say, in the macro, there is no reason for us to believe that the measures are going to undermine the ability of providers to give good-quality care to individuals.

Senator SIEWERT: Dr Hartland, in calculating those factors it is commonly acknowledged, and I think it is agreed, that people going into aged care are going in later and that frailty is increasing. I am presuming that in your figures, you have factored that in. Is that what you are saying?

Dr Hartland: Traditionally, we have allowed for growth in frailty. In essence, the dispute between myself, Mr Murray and the Secretary has been whether the frailty that we observed in the claiming practices matched what we thought was the real case and, as Dr McCarthy points out, we formed a view that the claiming that we saw was over and above what could be accounted for by an increase in frailty.

Senator POLLEY: Why did you not target those people who you believed were over claiming?

Dr Hartland: I can understand that point.

Senator POLLEY: The minister accused the sector of rorting.

Dr McCarthy: Senator, no-one has accused the sector of rorting.

Senator POLLEY: The minister did.

Dr McCarthy: I have not seen any reference to the minister using that turn. I referred earlier to ambiguities in the instrument such that it is very difficult to prove whether someone is maximising—to use that term—versus providing the level of care that a person needs.

Senator SIEWERT: I take your point—and I think there is general agreement in the sector that the instrument is now getting past its use-by date—so is there a proposal for a) reviewing the instrument and b) for a cost-of-care study, which the sector has been calling for for as long as I can remember?

Senator POLLEY: And will that be part of the review.

Dr Hartland: We have initiated work on doing the preliminary work to put us in a position to advise government on taking the tool out of the hands of providers and—

Senator SIEWERT: I am sorry?

Senator POLLEY: We cannot hear you.

Dr Hartland: I am sorry, I am not being very clear. I apologise. We started work on alternatives to the ACFI with a particular focus on tools and methods that could be used independently of providers. We think that the basic structural problem we have, which kind of includes the ambiguity of the tool, is that providers are determining needs assessments and determining the funding they get. Obviously that puts a whole lot of incentives into a system that are hard to control no matter what tool you have. We have started that work and Minister Wyatt's commitments to the National Aged Care Alliance were: he would share the parameters—we have talked about that; he would work with alternatives—we talked about that; and he would work with the sector on longer-term options including external assessment—and we have started work on that. We have talked to the sector committee about how we will engage with them—we have commissioned the University of Wollongong to undertake some initial work for us on that—and we will do that quite openly with the sector.

Senator SIEWERT: So that I am clear when we walk out of this room: when you talk about longer-term approaches, it means reviewing ACFI or redoing ACFI?

Dr Hartland: Yes.

Dr McCarthy: Probably the most precise way of talking about that would be to say that we are reviewing how to do care needs assessment.

Senator SIEWERT: Sorry?

Dr McCarthy: We are reviewing how to assess the care needs of residents. ACFI is a particular tool—

Senator SIEWERT: So you are going one step back and saying, 'We had a review'.

Dr McCarthy: That is right.

Senator SIEWERT: Is the cost of care involved in that as well?

Dr Hartland: No, there has not been a commitment by the department or the government to undertake a cost-of-care-study at this point.

Senator SIEWERT: Why is that?

Dr McCarthy: Among other things, the cost of care depends in large part on the different models that different providers use—whose cost of care in any cost-of-care study would you

be using? Again, the work of the Aged Care Financing Authority shows there is quite a diverse range of results in the sector, as you know. That is not just to do with care—

Senator POLLEY: Just before Dr McCarthy moves away from the ambiguities in the instrument, why do you not just remove those?

Dr Hartland: In a sense, that was the intent of the budget measure that the government announced.

CHAIR: Thank you, Senator Polley.

Senator POLLEY: I will come back.

Senator SMITH: I want to traverse some similar questioning to that raised by Senator Polley and Senator Siewert. Then I want to come back to the issue of frailty. The 2012 expenditure overrun in the ACFI was valued at about $1.6 billion. How is that rectified?

Dr Hartland: The 2011-12 estimates variation was $2.3 billion.

Senator SMITH: It was $2.3 billion, not $1.6 billion?

Dr Hartland: There was a $2.3 billion estimates variation made at that time and a $1.6 billion save was announced.

Mr Murray: At that time, the then government announced—following a very similar pattern to what has happened this time around—more detailed changes to the ACFI funding instrument. There were then some discussions with the sector following on from that and they reconsidered their position at the time. They then proceeded with changes to the ACFI to achieve the savings and that was done through a mixture of changes to the funding instrument—they changed some questions and how they were scored and funded—as well as a one-year indexation pause.

Senator SMITH: So was what sounds to me like an unprecedented measure—sharing the modelling of the budget parameters with industry—part of the 2011 solution?

Mr Murray: I do not believe there was full modelling released. It was similar to this set of circumstances. There were discussions with the sector and there was some information released, but it was not like the full model was released.

Senator SMITH: Except in this situation more information, and information that might be regarded as more sensitive, has been shared with the industry.

Mr Murray: Certainly there have been those discussions with the committee which Dr Hartland mentioned. There is also information, which is published on a monthly basis now, which is much more detailed than previously that goes through all the areas of growth in the ACFI instrument and identifies where those areas are.

Dr McCarthy: That is in response to the sector asking us to share with them more frequently and in more detail what the claiming looks like so that they can partner with us in, hopefully, bringing things back to trend.

Senator SMITH: And on the basis of that the confidentiality aspects becomes very important because more and more of these entities are commercial.

Dr McCarthy: Actually, the data that Mr Murray is referring to in relation to what we publish on claims—

Mr Murray: That is aggregate information.

Dr McCarthy: It is aggregate information that is made public. The more detailed information we share privately.

Mr Murray: While it is aggregated it also gives some breakdown by regional area and for-profits and not-for-profits at that aggregate level.

Senator SMITH: What percentage of the ACFI claims have been over claimed or come in higher than expected?

Dr Hartland: In 2014-15 we were projecting real growth—growth that we could attribute to frailty creep, which we talked about, at 3.2 per cent. The claiming patterns were at 5.2 per cent, so a two per cent unexpected increase in that dimension.

Senator SMITH: I am interested in the issue of unexpected growth. I have got a lot of sympathy for the arguments that the industry has been running, don't get me wrong, but if the frailty argument is to withstand some contestability then surely the unexpected growth should show up in certain areas in the ACFI in order to meet that frailty argument. Is that correct?

Dr McCarthy: You would expect to see the unexpected growth appear more consistently across all aspects of the instrument. The discussions that we had with the sector very early on about why this might be happening focused on the fact that it was quite sudden and quite high in just one part of the instrument.

Senator SMITH: You did say it was a sudden and sharp increase. Where did this sharp and sudden increase show up in the ACFI?

Dr McCarthy: It showed up in a domain called complex health care.

Senator SMITH: Medication and complex health care?

Dr McCarthy: Yes. There are some various elements to that part of the instrument that Mr Murray can talk about if you would like more detail.

Mr Murray: There are three domains: activities of daily living, behaviour and complex health care—as Dr McCarthy mentioned. If it was genuine frailty growth, you would have expected to see an increase across all of those three domains but, in fact, it was only really complex health care where there was significant growth and, even within complex health care, only specific, targeted questions.

Senator POLLEY: Can you tell us what that actually means?

Mr Murray: The way the ACFI works is that the provider looks at the individual care recipient and assesses their needs. There are a bunch of questions which they ask about the individual, and they then go through those for activities of daily living—nutrition, mobility and those types of things. Depending on the answers to those scores, you then get a funding arrangement that comes out of that. Similarly, they ask questions for the behaviour domain—cognition and needs around that. Depending on how you answer those questions, they will give you a higher or lower score which affects your funding. Similarly, on complex health care, there are a range of questions. Within complex health care, for example, there are questions around pain management, there are questions around medication delivery and there are questions around palliative care and other types of treatments.

We saw that there wasn't the same increase in activities of daily living, behaviour and complex health care. If it was a genuine frailty increase, you would have expected those to be

moving much more in line together, because, if someone is generally frail, it would impact on all those domains.

Senator SIEWERT: Did you ask the sector providers about it?

Mr Murray: Yes. We had this discussion with the providers and we provided a fair bit of information to them which explained how this is happening and this exact argument: that genuine frailty growth would not be isolated to one particular area of one particular domain. It was also the fact that it was quite a sharp increase in the 2014-15 and 2015-16 years. Again, if it is genuine frailty growth, you would expect to see a fairly constant increase. It is not like the day turns over and people are suddenly more frail. But we saw quite a sharp increase as well.

Senator SIEWERT: What was the sector's response when you talked to them about it?

Dr McCarthy: In the early part of those discussions, the sector put to us a whole range of hypotheses about why this might be the case—initial diagnosis, type of service, length of stay—and we could not make any correlation between the hypotheses and what we were seeing.

Senator SMITH: I think that gives a lot of clarity in terms of the challenge that the government is being asked to address—that is, the sharp and sudden increase in a narrow part of the ACFI at a time when, fair enough, aged-care providers might be looking for a bit more financial security. I totally get that, but the government's task is one of financial prudence.

Is there a particular profile of those aged-care homes that are most concerned or impacted? I will give you an example: in Western Australia, aged-care homes that have—I was schooled in the Bronwyn Bishop school of aged care, where we call them 'homes' and not 'facilities'. The Jewish aged-care home, which I know Dr McCarthy has been to, in Menora—some of the culturally or ethnically specific homes have raised concerns with me. Is there a particular profile of an aged-care home that is most affected or most concerned by these, or is it across the board?

Dr Hartland: The effect of the budget measures, obviously, has a greater impact on homes that are high in the complex health care domain. If a home is not making high claims in complex health care, they are not as greatly affected by the budget measures compared to a home that has started to make high complex gain. I think this is the case for many of the providers that come to us—and, no doubt, also put their cases to members of parliament. Where you stand is where you sit or vice versa—it is a bit late in the night to get the metaphor right.

The measure, as I said, has a heavier impact on homes that are high in CHC, because that is what has changed. It is the criteria that you need to tick to get higher scores in CHC.

Dr McCarthy: Can I just also point out, of course, that the measure does not take effect overnight, and existing residents—

Senator SMITH: That was where I wanted to get to at the very end. Senator Polley, do you have questions on a similar line?

Senator POLLEY: Yes. I was just going to say that the department would know exactly who the providers were that had the sudden spike in claims.

Dr Hartland: Yes. This, in a way, tracks us back to the argument about whether this spike is rorting or what we would call, trying to put it into value-neutral terms, upcoding.

Senator SMITH: Upcoding?

Senator POLLEY: Upcoding—that is a new one!

Dr Hartland: I am trying to use terms that do not appear to involve judgment about morality.

Senator SMITH: Yes, let's use 'upcoding'!

Dr Hartland: We are seeing if upcoding will stick. If it sticks, we will be very happy and we will not have to have a discussion about whether we were accusing people of behaving dishonestly. We have not taken the position that this is because of fraudulent behaviour. If you take that—that it is not fraudulent behaviour; it is using the ambiguities in the tool to code up people where there is a possibility to do that—then, while you might see a spike in a provider, that is a spike that would be claimable under the rules.

To address that, you cannot treat it as a fraud issue; you actually have to change the rules to take that back down to where you thought it should be. If you change the rules, then you change the rules for everybody, otherwise you have a system with one set of rules targeted to people you like and another set of rules targeted to people you do not like, and that is not viable. So while we understand that viewpoint, 'Why don't you just go for the people that have suddenly spiked?', it would still get you back to having to change the rules, which would affect, therefore, all of the providers, whether they were upcoding legitimately or illegitimately.

Senator POLLEY: You could have increased the penalties for those people though. There were other options of dealing with this.

Dr Hartland: We certainly see as part of a balanced package of—I think if you step back and look at our relationship with the sector, having now had two experiences of the appropriation accelerating beyond what the governments of the day felt was reasonable, I think you would have to say that part of a balanced approach would be a focus on compliance. As you know, there was a bill passed just recently that included some additional compliance measures. We will be actively looking at how we can better target ACFI reviews, but, as I said, we do not believe that this is—at the moment, because of fraudulent or rorting activity, it is a matter of incentives and coding people up where there is ambiguity. That is an important part of what we do, but it is actually not ever going to be the only solution to rebalancing our relationship with the sector and putting the appropriation back on a more planned growth path.

Dr McCarthy: Which is not to say, of course, that there are not claims that are downgraded because they are found to be claims for which there is no evidence. In 2015-16 some 15,763 reviews were undertaken, with 15.9 per cent of reviewed claims downgraded and one per cent of claims upgraded. The ambiguities that Dr Hartland is referring to—the upcoding—the difference between what the claim should be for the resident and the ambiguity that might be taken advantage of actually represents an inefficient use of funding, which is why, as Dr Hartland explained, we need to, in the first instance, change the rules but, in the longer term, find a much better way to do this assessment of people's care needs.

Senator SMITH: That is fair enough, as the character or care needs of residents are changing over time. It is not remarkable that the ACFI might need to be improved upon. Would you agree with that?

Dr McCarthy: There is no argument.

Senator SIEWERT: No one is arguing that. We think there needs to be.

Dr McCarthy: No.

Dr Hartland: We have got very few friends in this room, I think.

Senator SMITH: This is my last point. Dr Hartland, you talked about the expected per person cost from 2015-16 being $59,900 and it going up to $66,594 in 2019-20. This may not be a useful exercise, but, if this issue was not addressed, what does the per person cost become in 2019-20? Is it 5.2 per cent greater than $66,594?

Dr Hartland: I do not have that figure. It is a bit late in the evening to be doing maths!

Mr Bowles: It would not be 5.2 per cent. The current growth to get to $66,594 is 5.1 per cent per annum in the out years.

Senator SMITH: Okay, I will put that on notice.

Senator POLLEY: Considering that we are fast running out of time, I just to clarify ACFI before we move on. There is a review that has to be undertaken by June next year of the living longer living better legislation. Are you also, at that time, going to do a total review of ACFI and have that independently assessed?

Dr McCarthy: The review you are referring to is the review that Mr David Tune has been appointed to undertake, and I think he has until August next year to do that. The terms of reference in the legislation for the review does not include a review of ACFI. We have already, effectively, begun reviewing it and we would not want to delay that work until August. I have no doubt that the submissions to Mr Tune will probably have a lot to say about care funding, even though it is not part of the terms of reference. But it is not part of what he has been asked to do, and we have already started that work. As Dr Hartland indicated, we have contracted some external expertise to help us do that, and we will be working on that very openly with the sector.

Senator POLLEY: Can you tell us who those experts are or table that for us?

Dr McCarthy: Are you referring to their consultancy or those sector representatives?

Senator POLLEY: No, the consultants.

Dr Hartland: We can give you a bit of information about that, of course.

Mr Murray: We have engaged the University of Wollongong to do some initial work for us looking at alternative options to the current ACFI as the funding model. As part of that work, they will be looking at international models, for example, and determining what we can learn from overseas experience. They are also obviously looking at other sectors as well within health, such as the hospital funding et cetera, and seeing if there are different ways we can look at getting what both the government and the sector want, which is a more sustainable and stable funding model going forward and one which does not have the limitations that the current ACFI does. Every few years we see that growth goes up high, and government has to react to that, so we are very keen to get them to do some work starting with an open slate as to

what type of options they might find and come back to us with. As they do that work, we will obviously then consult with the sector on an ongoing basis to get their views and input on those models as well. Ultimately we would obviously—if we are going to go down these paths—need to give consideration to piloting and trialling any different types of funding models as well, so all that type of work is what we would be planning to do.

Senator SIEWERT: What is the time line for that? Did you say that before and I just did not write it down?

Mr Murray: There is not a strict time line at the moment. Certainly we are looking to get some of the initial work done over the next four or five months in terms of working out some general directions, but we will be consulting with the sector. It will be a very iterative process as we take that forward.

Dr McCarthy: Introducing a new tool is not something that we would want to rush into. ACFI took five years to develop. We want to go more quickly than that, certainly, but we do not want to go at such a speed that we might unwittingly buy everyone a whole new set of problems through not trialling options properly.

Senator POLLEY: It has been reported by Catholic Health Australia that the department recently called tenders for examination of alternate aged care assessment classification and funding models—is that correct?

What is the budget for this tender? Can you provide the terms of reference for this examination?

Dr McCarthy: That was the work that Mr Murray just referred to. I do not know if we have any additional information on it with us.

Senator POLLEY: Not where that is at?

Mr Murray: We have just engaged the University of Wollongong to start this work, so it is very much at that preliminary scoping stage at the moment.

Senator POLLEY: I have a lot more questions around ACFI which I am happy to put on notice because we have some other things. If it is okay, can I just turn to something else I tried to raise earlier today in relation to the My Aged Care gateway? Has the department contracted or is it considering contracting any aged-care services that help older Australians navigate the aged-care system?

Dr McCarthy: We have a range of mechanisms in place to help older Australians navigate the aged-care system, ranging from printed information that we have made available, for example, in doctors' surgeries, through pharmacies and in hospitals through emergency departments. I know that in the ACT information is provided to older people in the emergency department about My Aged Care and the process for entering aged care. The My Aged Care website and contact centre itself also provides information for older people and their families, because it is often the case that older people are being assisted by family members to navigate the system. So there is information available online. Of course, we know that not everyone wants to go online, so older people or their carers or families can speak to a member of the contact centre. We also have available the Homecare Today website, which we fund COTA to run, which provides information specifically about home care. We also fund advocacy services for older people that they can access even before entering the aged-care system to

find out more and understand what their options might be. Ms Buffinton and Ms Balmanno both do work in this area and might have something to add.

Ms Balmanno: I am happy to elaborate on the advocacy services, for example.

Senator POLLEY: We are not going to have time, but you can take those on notice. I was particularly interested in the homecare package reforms and whether any businesses or similar services are being provided.

Ms Buffinton: In terms of getting ready for February 2017, which is what I am assuming you are referring to, we will be supporting individuals. Rather than being referred to a service, they will have the opportunity of being supported to select their homecare service. That is in addition to what Dr McCarthy was talking about, which is a whole range of new information both online through the contact centre and materials from the aged-care assessment teams when they go out and do the comprehensive assessment, which is the gateway to home care. All of that information through the ACATs will be supporting consumers and outlining to consumers what their choices will be. There is also the opportunity of working with the advocacy services that Ms Balmanno was referring to. In the case of the aged-care assessment teams, for those who are particularly vulnerable—for example, homeless people—they will be putting in place some special supports to assist those more vulnerable individuals in making the choice. Is that what you were referring to?

Senator POLLEY: Can I ask specifically how you are going to communicate with those in our community who will be seeking out homecare packages with the reforms that will take effect in February? How are you communicating with them?

Ms Buffinton: For those who are already Home Care Packages, we will be writing to them in the next couple of weeks and will outline the changes. If they are happy with where they are, of course, they can stay where they are. But we are also going to be outlining to those who are already in the system that the February 2017 changes are for them as well. They have a choice to move to alternative providers. Clearly, those who are coming in from February 2017 will not know another system. Right from the start they will be on a basis where they will be supported to make a choice of provider, and they will know that they can choose to move provider in the future. At the moment, if they want to move cities to be closer to family they cannot make that choice. All those choices will be outlined to them.

Senator POLLEY: Do you have an indication of how many letters you will be posting?

Ms Buffinton: About 180,000 letters. We are going to be writing to those who are already in home care. We are also going to write to those who have an active ACAT—so, a comprehensive assessment—who have not yet taken up either residential care or home care.

Senator POLLEY: Have you contracted anyone to help disseminate this information?

Ms Buffinton: This is where we are working through Healthdirect and Stellar, who are the My Aged Care gateway contact centre operators. We will be working with them both in sending the letters out and in calls coming back into the call centre. That is part of the broader My Aged Care contract.

Senator POLLEY: On Sunday a week ago, when the minister, Senator Siewert and I were participating in a Q and A at the LASA Congress, I raised the issue of the lack of knowledge by the general community, the older Australians, as to what these reforms were about. I suggested that there could be an advertising campaign. In fact, I thought there should

be an advertising campaign. Has the minister sought any advice from the department recently in relation to running an advertising campaign?

Ms Buffinton: We did our last major advertising campaign in 2014. We have been doing a lot of work both from when we started with My Aged Care and now moving into the changes for increasing choice—so the mid-2015 changes now moving to February 2017 changes. You might recall we have discussed at previous hearings information on screens and GPs using Tonic Health Media, the Pharmacy Guild working on the backings for all the pharmacy scripts and so forth, and advertising through a whole range of magazines. We have a range of measures that are about to start going into the market, with three months to go.

It is not coming too early ahead of February 2017. We will be doing a lot of that work, following up more broadly on increasing choice but also the changes that have come in with settling My Aged Care, because we have had discussions about the need to settle that. As a department, and with government, we certainly are talking about the potential opportunity of broader promotion when moving into 2017.

Senator POLLEY: Can I seek some advice as to whether the department or the government has had any contact with a company called Care Guidance?

Dr McCarthy: That is not a name familiar to me. That does not mean that someone has not had a contact with them. We can take that on notice.

Senator POLLEY: If you could. Perhaps Senator Nash could enlighten us as to whether the minister's office has had any discussions with that company, Care Guidance.

Senator Nash: I am not aware of any, but I can take that on notice.

Senator POLLEY: Thank you; that would be helpful. AusTender contract notice CN3366649 advises that the department has signed a contract for social media listening services with Lexer. What is a social media listening service?

Mr Bowles: In relation to aged care? This sounds a bit—

Senator POLLEY: That is what I am trying to find out.

Mr Bowles: We can take that on notice. I have not heard that.

Dr McCarthy: I do not know that that is to do with—it does not sound like ours.

Senator POLLEY: Can you please provide, on notice, what the department is listening for, a list of keywords and terms which are being monitored—this will help you when you take it on notice—an update on the structure of the department, and the current staffing levels at the department and how it compares to 12 months ago.

Mr Bowles: And we are not talking about aged care anymore; we are talking about the department?

Senator POLLEY: Yes.

Mr Bowles: Right, we have gone back to the portfolio.

Senator POLLEY: I am just trying to see if you are on the ball!

Mr Laffan: I have been here for 13½ hours; however, I still picked that one up.

Senator POLLEY: We are running out of time.

CHAIR: We are. Thank you.

Senator GRIFF: I have a few questions in relation to the complaints process for elder abuse. I will direct these to the commission, the department and the Aged Care Quality Agency as appropriate. When the department receives a complaint under the compulsory reporting regime, how does the department make an assessment of the alleged abuse?

Dr McCarthy: I think we are talking about two slightly different things. Complaints are now directed to Ms Lamb, the Aged Care Complaints Commissioner. I think you might be talking about a contact about a reportable assault.

Senator GRIFF: Yes.

Dr McCarthy: The department can answer that question and Ms Lamb might want to add to it.

Mr Laffan: The department overall has responsibility for compulsory reporting of reportable results. When we receive those calls from providers, the department makes an assessment as to whether the providers met their statutory responsibility to report to the police and to the department within a certain time frame.

Senator GRIFF: If video evidence of the alleged abuse is provided, is that considered?

Mr Laffan: That is something that is considered by police.

Senator GRIFF: So you would not consider that at all?

Dr Hartland: The system around reportable results is primarily designed to make sure that providers report an assault, or an alleged assault, quickly to the police, who are best placed to deal with that matter. It is, after all, essentially a criminal act, and the most important thing is that gets dealt with promptly by the appropriate law enforcement body. We do not ask for evidence of a nature about whether the act occurred or what type of act it was; our role is to have a system in place that provides an assurance that providers are getting these allegations to the police promptly. The video evidence may be relevant to the police, but that is a matter for the police. We cannot speak on behalf of the police force. What we are trying to do in our systems is to ensure that any allegation of, or suspected, assault gets very promptly dealt with by the appropriate authorities—in this case, law enforcement.

Dr McCarthy: And those reportable assaults are, of course, also part of our regulatory intelligence system, in terms of information that might be appropriate to share between different parts of the framework that provides for safety and quality.

Senator GRIFF: How many of those compulsory reports would have proceeded to prosecution?

Mr Laffan: That is not information that the department tracks.

Senator GRIFF: You would be aware of the case of Clarence Hausler in South Australia, I would imagine.

Mr Laffan: Yes.

Senator GRIFF: He has advanced dementia and was abused at the Mitcham Residential Care Facility. We all know the abuse was quite horrific and that it was captured on a camera that was installed in his room by his daughter, Noleen. The footage prompted a police investigation and subsequent criminal charges. The South Australian Attorney-General met with Ms Hausler and confirmed that the footage was not in breach of the state's surveillance legislation, because it was of personal or public interest. Given what Mr Hausler and his

family have been through and the effect that the video footage had on the successful prosecution of an aged-care worker, is the commission considering accepting camera evidence for future complaints?

Ms Lamb: All I can really say publicly about this particular case, because it is protected information under the Aged Care Act, is that I can confirm we have a complaint and we are working very closely with the people involved in dealing with it. In terms of whether or not, from a general perspective, we accept things like video evidence, photographs—those kinds of things—if we have a complaint and a complainant submits that kind of material to us, we will, of course, look at it.

Senator GRIFF: I have just one more brief question. I would like to move on to something fairly simple about nurse-to-patient ratios in aged-care facilities. We have seen a recent enactment of nurse-to-patient ratio legislation in Victoria. Given there are quite a few moves at state level, have there been any developments in establishing a national nurse-to-patient ratio in aged-care facilities?

Dr McCarthy: The Aged Care Act does not specify staffing ratios, on the basis that different services have different profiles of residents. What the Aged Care Act does legislate for—and, for example, what the Australian Aged Care Quality Agency, in its reviews, looks at—is whether the staffing is appropriate for that particular service.

Mr Ryan: We have 44 outcomes that every nursing home needs to meet. Outcome 1.6 concerns human resource management. Every home needs to evidence that it has a functioning system that is not just about the right staffing model but the recruitment of appropriate staff, proper supervision, proper ongoing staff development and so forth. We look for something far more systematic than a ratio or a number. What we look for is that the care needs of the actual residents within that home are fully and properly understood and assessed and attended to. We are aware that in different state jurisdictions there are concerns around the type of care staff—whether they are registered nurses, enrolled nurses, personal care workers. We would always look for appropriate clinical capability, and nursing is a key part of that, but we look for something far more systematic than that.

Senator GRIFF: But you have some facilities that say they have people on call but do not necessarily actually have someone available. That has been an issue in a number of aged-care facilities.

Mr Ryan: We hear claims of that nature from time to time. I would encourage every Australian, if they think that there is not adequate care and that the right care is not available, to refer it to my colleague Rae Lamb, if it is an individual matter, or refer it to us. We always take that on board. We do at least one unannounced visit every year for the 2,666 homes. We are vigilant in understanding the care needs and in ensuring that we work very closely with Rae Lamb and with the department. We work very closely to ensure that any concerns that are raised are looked at thoroughly and adequately follow up very quickly, where that is appropriate.

CHAIR: I think that concludes our consideration of outcome 6: ageing and aged care. Thank you.

[22:24]

CHAIR: We are now moving to outcome 5—regulation, safety and protection.

Senator POLLEY: Can I have clarified when questions on notice have to be in and when the date has been set for responses?

CHAIR: Questions on notice have to be in by close of business on 28 October.

Senator POLLEY: And the responses back?

CHAIR: From memory, I think, 2 December.

National Industrial Chemicals Notification and Assessment Scheme

[22:25]

Senator WATERS: Sorry about the lateness of the hour. I appreciate your time. I would like an update on the NICNAS national assessment of CSG chemicals. Given that I have been asking about this for just over four years now, when will it be done? Where is it at now?

Dr Richards: As I have advised previously, the national assessment is a project managed by the Department of the Environment and Energy from the Office of Water Science. NICNAS was one of the partners in the project conducting some human health risk assessments in relation to the surface handling of chemicals used in coal seam gas extraction. The timing of the release of the final reports from this project is a matter for the Department of the Environment and Energy, so I suggest that questions on that project be directed to that department.

Senator WATERS: I shall indeed, but since I have you I might press on. Can you clarify for me whether NICNAS's component of that assessment has been finalised?

Dr Richards: NICNAS prepared a number of technical reports as part of this project and those reports have been through a series of progressive edits to try and align the tone and the structure of the reports across the project. From our point of view, I guess I will be able to answer whether our role has finished in relation to those reports when I stop receiving versions for checking of edits as it goes through the communications preparation process and they are edited into a final consistent form across the project.

Senator WATERS: Can you tell me who those edits—

Dr Richards: From our point of view, there is nothing we are waiting to provide. But if asked for further checking of draft reports as they are finalised, I cannot say there is nothing—

Senator WATERS: Okay, to some follow-up questions on that. Are the edits coming from the department?

Dr Richards: Yes.

Senator WATERS: Are these edits substantive in nature or style?

Dr Richards: They are mostly style at this point. When did we submit is a complex question. It has been an iterative process with multiple drafts over, as you say, a long period of time.

Senator WATERS: Okay. When did you first submit the last of the series of technical reports? When did you submit all of the technical reports?

Dr Richards: We could receive another version tomorrow for our comment.

Senator WATERS: I understand that. I am trying to understand what is the delay and why and from whose end. Has it gone back and forth for the two years or has it only gone back and forth for the last three months? Can you give me a rough indication?

Dr Richards: These are questions for the Department of the Environment and Energy. They are managing the process. In addition to all the technical reports, the Department of the Environment and Energy is preparing communications material, including a plain English version, summarising the findings of the reports and various other comms material.

Senator WATERS: You said the edits were mostly style. Can you tell me about the substantive edits that were not style related? What did they pertain to?

Dr Richards: As I say, it has been a long and drawn-out process of iterative amendments. I am not sure how I would determine what is a substantive edit and what is a style edit.

Senator WATERS: From a science perspective?

Dr Richards: Nothing has changed from the science perspective other than when we get new data. As you would be aware from previous estimates' responses, any response to draft reports that were provided to industry industry provided more data and then we—

Senator WATERS: I will pursue the department on Friday. Do you have any sense of when the final deadline will be or is that, again, not your problem and is up to the department?

Dr Richards: That is up to the department.

Senator WATERS: Are you able to share with us any conclusions that you have been able to draw so far from the drafting of those technical reports?

Dr Richards: No. We have been contracted to provide the department with the findings and it is up to them to release the report.

Senator WATERS: Can I point out that, and correct me if I am wrong, more than six years after the federal approvals for coal seam gas were first issued, we still do not have the national chemical assessment of the impact of fracking chemicals on human health and the environment.

Dr Richards: That is your statement.

Senator WATERS: Is that correct?

Dr Richards: I do not know when the approvals were made.

Senator WATERS: October 2010.

Dr Richards: It is a matter for the Department of the Environment and Energy. We do not issue approvals.

Senator WATERS: I am glad I waited all day for that answer! Thanks very much, Dr Richards.

CHAIR: We have nothing more for NICNAS.

Department of Health

[22:31]

Senator POLLEY: Referring to the approach to the market for the Australian School Vaccination Register which closed at the start of the year, has the successful tender been selected?

Ms Appleyard: No, that tender evaluation process has not yet been finalised.

Senator POLLEY: When is it going to be finalised?

Ms Appleyard: I cannot provide you with an answer to that, but I am very conscious of the time frame that you are pointing to and we hope that it will not be too much longer.

Senator POLLEY: Am I correct in the assumption that this needs to start at the beginning of the next school year?

Ms Appleyard: That was the original intention, correct, that it be in place for the 2017 school year.

Senator POLLEY: Can you outline exactly what information would be held by the register?

Dr Somi: The register currently holds HPV vaccination data and the intention is to hold data on other vaccinations provided through schools based programs, and that includes DTPa—the pertussis vaccination—and varicella.

Senator POLLEY: Who currently holds this information?

Ms Appleyard: It is run by the Victorian Cytology Service.

Senator POLLEY: That is good. I did some work on that in the chamber recently. Is this the first time this information has been held by a private provider?

Ms Appleyard: The HPV register has always been under the custodianship of the Victorian Cytology Service.

Senator POLLEY: Is the department communicating with parents and schools about these changes that are going to impact on them next year?

Ms Appleyard: Because the tender has not been finalised yet, there would not be really anything specific that we would be communicated other than awareness of the fact that the register is moving to the ASVR from the HPV register.

Senator POLLEY: One would hope then that that advice would be out to them before the school year ends.

Ms Appleyard: Once we have advise to give, that would be the case, yes.

Senator POLLEY: how many applications were there in the tender?

Ms Appleyard: I am not sure that I can provide that information for probity reasons.

Mr Bowles: We are still in the tender process. It goes back to our conversation earlier today where we have a process and we do not want to breach our rules.

Senator POLLEY: Sorry, I must have missed that you were still in the tender process. You cannot tell me whether Telstra Health applied for that?

Mr Bowles: I cannot tell you who applied.

Senator POLLEY: Thank you to all the officers today.

CHAIR: That is everything for outcome 5. We will now to outcome 3, sport and recreation.

Australian Sports Anti-Doping Authority

[22:35]

Senator FARRELL: Thank you, Minister, and everyone else at the table for your persistence and sticking around for these questions. Mr McDevitt, I refer you to an ABC report on their website on 27 May of this year in reference to ASADA and it said: 'In the financial year ending 2014, ASADA had a total of 78 staff. By 2017 this will drop to 50. This has had impacts across all of ASADA's functions, including testing, investigative education and administrative units.'

If we refer to the ASADA annual report of 2014-15, it states that ASADA had an 'ongoing and non-ongoing staff totalling 66'. Can you tell us, if you can, whether the figures in the ABC story are accurate or whether the real figures for 2014 are closer to what is in the annual report?

Mr McDevitt: I do not have that article in front of me. I am probably better off to rely on our annual report statistics on funding and staffing. The point you are making is obviously that we have had a significant reduction in staffing over the past period. Going back to my own time with ASADA, I started in May 2014 and the average staffing level at that point was 80; at the moment, it is 52. We have an average staffing level going forward of 50. But I hasten to add there have obviously been several reasons for that and there was a surge capacity built into ASADA at the start of the Operation Cobia investigations. So some of the reduction was obviously due to the fact that, as that investigation unfolded, we were able to reduce the number of staff.

We also reduced staff in response to our collections capability and we deliberately introduced a strategy of conducting fewer tests. The reason for that was to move to a strategy of having a much more intelligence-based, targeted program. I deliberately reduced collection staff and instead increased energy and effort put into intelligence staff and investigators. Part of this is a different model where you end up with a smaller staffing footprint, but I think the statistics speak for themselves. Even with a smaller staff, you can actually increase your success rate and hit rate. I am not saying I could not do with additional staff, and you will never get a CEO sit here and say that to you, but we do the best we can with what we have.

We have also moved to a shared services model, where the secretary has entered into arrangements with us to provide support to us, and that has had an impact on staffing as well. As an example, it is things like IT support, building security and those sorts of things. The shared services model has an impact. Of course we, just the same as other agencies, have had to deal with the ongoing efficiency dividends and so on. So we are living within our means and are doing the best that we can. I still believe we are, despite the staff reductions, one of the most effective anti-doping organisations in the world with what we have.

Senator FARRELL: We have the Commonwealth Games coming up in less than two years now, and I would assume your requirements are going to ramp up as we build up to that. Have you got the resources, as you have explained it today, to deal adequately in the lead-up to the Commonwealth Games?

Mr McDevitt: I am confident that the Brisbane games will be probably one of the cleanest games ever in terms of Commonwealth Games, and I say that for several reasons. In the recent budget, the government gave us an additional $1.48 million, specifically for Commonwealth Games funding, and that is so we can conduct an extra 750 tests, both internationally and in Australia in the lead-up to the games.

Senator FARRELL: What was the figure?

Mr McDevitt: $1.48 million.

Senator FARRELL: Yes, that was the quantum, but for—

Mr McDevitt: That is specifically to do additional tests.

Senator FARRELL: Did you mention a figure?

Mr McDevitt: Yes. I mentioned 375 internationally—sorry, I might have said 350—and 375 domestically. That will not be the total testing figures. That will be in addition to in the order of 2,000 tests we will do ourselves. The reason I say it will be so successful is that in our engagement with the Commonwealth Games Federation and with GOLDOC, the plans we are proposing are actually aimed at leveraging resources from other Commonwealth national anti-doping organisations. As an example, we will bring doping control officers from places like the UK and other Commonwealth countries to assist in delivery of the program.

We do have some specific additional funding, and we are very conscious of the Commonwealth Games. It is really our highest priority between now and 2018. And if I feel that we are not financially in as good a position as need be then I will certainly agitate to get additional funding.

Senator FARRELL: What form would this agitation take?

Mr McDevitt: I would make submissions but, at this point, I am comfortable with the additional funding we have been given by government in the budget.

Mr Bowles: Trust me, Senator, he would be talking to me on a regular basis.

Senator FARRELL: And are you in a position to make that decision without consultation with the minister?

Mr Bowles: The normal process would be that we would make a submission to the minister through the normal budget process. We will do that anyhow in the context of broader government related issues in relation to the Commonwealth Games.

Senator FARRELL: And what would the minister's response be, Senator Nash?

Senator Nash: I would have to take that on notice.

Senator FARRELL: Could you do that, please?

Senator Nash: Yes of course. I meant by indication that I would be doing that.

Senator FARRELL: Obviously there has been a relatively significant reduction. I think the figure has gone down from 80 to 52 as you said. Were there any redundancies in that?

Mr McDevitt: Yes. Sorry, did you say eight?

Senator FARRELL: Is the figure 28, the difference between 80 and 52?

Mr McDevitt: No, they were not all redundancies that we had. There were a number of redundancies.

Ms Perdikogiannis : They were a combination of redundancies and natural attrition so non-replacement of staff.

Senator FARRELL: As people left, particularly from some of these specialist areas, you did not replace them?

Ms Perdikogiannis : That is correct.

Mr McDevitt: The staffing model also required the acquisition of new skill sets. A part of what we have done also is engage some secondees so we had Australian Federal Police secondees, a Border Force secondee and that sort of thing. It is more about getting the intelligence dividend and engaging that way so it is a different sort of employment construct.

Senator FARRELL: Are you able to tell us or can you find out what the payments were for those redundancy payments?

Ms Perdikogiannis : Not to hand. We will take that on notice.

Mr McDevitt: We will see if we can provide that for you.

Senator FARRELL: So obviously with the extra $1.5 million, you are going to do extra tests. What does that mean in terms of employment for the organisation? Do your deployment numbers now ramp up again in the lead up or is it by some other mechanism you spend that?

Ms Perdikogiannis : I should say by way of background, we employ 179 casual field staff. Our staff, who are located all over the country, and their workloads vary with our testing program. At this stage, we anticipate that on our present numbers we will have sufficient field staff to conduct that pre-games testing program.

Senator FARRELL: What do you spend the $1.5 million on if it is not staff?

Ms Perdikogiannis : We spend it on analysis primarily.

Senator FARRELL: Do you do that in-house?

Ms Perdikogiannis : Almost all of our tests that we collect are analysed at the Australian Sports Drug Testing Laboratory, which is a division of the National Measurement Institute. ASDTL is located in Sydney. We have a memorandum of understanding with the lab which is for approximately 5,000 tests per annum.

Senator FARRELL: Are you required to pay for those tests?

Ms Perdikogiannis : Yes.

Senator FARRELL: I am trying to work out where the money is going. I take it that if it is not going to extra staff then it is going into payment for—

Ms Perdikogiannis : It will go into our staffing costs to the extent to which casual staff are employed for greater numbers of missions.

Mr McDevitt: It will be a combination. There will be some reimbursement of NADOs in other countries, who will send out their staff to conduct tests on our behalf and we will reimburse them and that sort of thing.

Senator FARRELL: Are you able to say how your testing program—particularly in the lead-up to the Commonwealth Games—and the funding and the staffing that you have compare with other countries?

Mr McDevitt: With other Commonwealth Games?

Senator FARRELL: No, with other countries who would be conducting Commonwealth Games.

Mr McDevitt: I would have to take that on notice to be able to give you detailed figures. It is a little difficult, say, if you are comparing what we are envisaging for the Brisbane games as opposed to the Glasgow games. For example, there are some critical differences, such as our costings will involve keeping the samples that we collect at least seven years, whereas

after Glasgow they were not kept, so there are some costs associated with that. There is also a new anti-doping code in force with additional offences that we will have to put energy and effort into and that sort of thing. And, we will be producing quite an extensive education program that we would like to be able to promulgate to other Commonwealth countries—advice to athletes on how this will work—

Senator FARRELL: In the lead-up to the games?

Mr McDevitt: In the lead-up to the games—yes.

Senator FARRELL: I will put my further questions for ASADA on notice.

Senator KAKOSCHKE-MOORE: The topic I would like to ask some questions about tonight is whistleblowing and whistleblower protection. I saw that on ASADA's website, on a post that was made on 6 June 2016, there was a call-out for whistleblowers. On the website, it states that tip-offs will always be treated in the strictest confidence. Can you explain to me what procedures ASADA has in place to protect whistleblowers and to ensure their secrecy?

Mr McDevitt: I think the first point I would make is that this is definitely a work in progress. Prior to coming to ASADA, my career has been in law enforcement in seven different law enforcement agencies and, to be totally frank, I am yet to find a law enforcement agency that can really guarantee the ultimate protection for whistleblowers. It is a difficult issue. It is hard to manage. WADA, itself, at the moment is going through a process of trying to identify with us, as a group of NADOs, the best way to encourage whistleblowers to come forward and provide the sorts of protections that you would need to guarantee their safety and protection.

Senator KAKOSCHKE-MOORE: Are you satisfied that your current procedures would offer enough protection to give whistleblowers some comfort to come forward?

Mr McDevitt: I think you have got a be honest with what you can promise and with what protections you can actually give to them.

Senator KAKOSCHKE-MOORE: Was it a little premature to make a call-out in June if they were not—

Mr McDevitt: No, I do not think so. I think that people coming forward and actually identifying where there is inappropriate activity—and in this case they are saying that people are cheating—is a really important source of information for us. We get quite a bit of information from whistleblowers, from people actually coming out, but I think you have to be very cautious and careful about what you actually can promise. I must say this policy framework, this set of protections, is not as advanced as I would like to see.

Senator KAKOSCHKE-MOORE: Do you have in mind a timeframe for when you would like to have these policies further advanced?

Mr McDevitt: I think the way it will work is: as a global set of principles and as a global arrangement. I think it will quite possibly involve other agencies, such as law enforcement and so on, depending on what is actually required. You can envisage—and I think it is probably public knowledge—that quite often with whistleblowers you require a set of strategies which might involve relocation to another country. It might require giving people new identities and all sorts of things. So it can range from some pretty basic stuff, depending on what the threat is that you are dealing with. But I do not think it is ever too early to

actually say to people, 'Hey, look: if you're seeing malpractice, if you're seeing offences being committed, then come forward, and we'll certainly do whatever we can.'

CHAIR: Sorry, Senator Kakoschke-Moore, I am just mindful of the time. Senator Farrell did indicate that he wanted to move on to the Sports Commission.

Senator KAKOSCHKE-MOORE: Could I just ask a couple more questions, if I keep them short?

CHAIR: Very short, because we have five minutes.

Senator KAKOSCHKE-MOORE: In that case—and you may need to take this on notice in any case—could you tell me how many people have come forward since the call-out on 6 June as a result of—as I say, you can take that on notice.

Mr McDevitt: I think is probably easier if I do take it on notice.

Senator KAKOSCHKE-MOORE: I would also be curious to know whether or not ASADA supports any changes to Australia's whistleblowing laws in general. So we are talking at a corporate level or thereabouts. Again, I am happy to put some more detailed questions on notice—just to flag with you that this is the type of information that I am after.

CHAIR: Thank you, officers from ASADA. We will move to the Sports Commission for four minutes.

Australian Sports Commission

[22:57]

Senator FARRELL: I would just like to refer to a recent statement by the ASC Chairman John Wylie. He said:

A major challenge for the ASC is the substantial reduction that has occurred in our appropriation funding…in no small measure due to the application of an annual efficiency dividend to the entirety of the ASC's appropriation funding…

I note that funding in the portfolio has gone from $340 million in 2014-15 to $304 million in 2015-16, and is expected to be $289 million in 2016-17. Based on these current funding levels, could you tell us whether the ASC will be able to effectively pursue its strategic priorities?

Mr Favier: Over the last four years, the commission has attempted to make adjustments around a number of our programs, including significant changes, or changes rather, to our workforce. A combination of reasons has led to that—one being that we have changed some of our programs. So our workforce has reduced in scale and size. The role of the AIS further has changed over the last four years since the London Olympic Games. We are mindful, as with other agencies, that our resources have adjusted and that we have needed to make changes to our activities. At the same time, we have worked to develop a new corporate plan—a new corporate strategy—which has been very clear about our pursuit of both high performance and participation of genders. I think that the resources that we have will allow us to continue to pursue both of those ambitions.

Senator FARRELL: To what extent are these efficiency dividends eating into your ability to hand out your grants? You have mentioned that you have managed to get by so far with a reduction in staff, but there are further reductions to come. I suppose the question I am

asking is: will it start eating into your ability to distribute grants in the way that you are doing it at the moment?

Mr Favier: We are planning for a number of scenarios that will consider the effect of the efficiency dividend to our total appropriation, and that will include consideration given to the grants supplied to sports.

Senator FARRELL: So there is the potential for some impact on the grants as a result of these efficiency dividends?

Mr Favier: There will be—yes.

CHAIR: I am sorry, Senator Farrell. It being 11 o'clock, I am afraid if you have further questions you will have to place them on notice, as much as I would like to keep going. That does conclude the examination of the health portfolio. I thank the minister, the officers—the ones that got away—for their attendance, and Hansard, broadcasting and the secretariat staff, as well. Senators are reminded that written questions on notice should be provided to the secretariat by close of business on Friday, 28 October. We will reconvene tomorrow at 9 am to examine the Department of Social Services.

Committee adjourned at 23:00