COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Estimates

TUESDAY, 29 MAY 2018

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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Tuesday, 29 May 2018

Members in attendance: Senators Abetz, Brockman, Carol Brown, Di Natale, Dodson, Farrell, Griff, Leyonhjelm, Lines, Martin, O'Neill, Polley, Pratt, Siewert, Singh, Dean Smith, Steele-John, Urquhart, Watt.

HEALTH PORTFOLIO

In Attendance

Senator the Hon Bridget McKenzie, Minister for Sport, Minister for Rural Health, Minister for Regional Communications

Whole of Portfolio

Ms Glenys Beauchamp PSM, Secretary

Professor Brendan Murphy, Chief Medical Officer

Mr Daniel McCabe, Acting Deputy Secretary, Corporate Operations Group

Ms Caroline Edwards, Deputy Secretary, Health Systems Policy and Primary Care Group

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

Ms Penny Shakespeare, Acting Deputy Secretary, Health Financing Group

Dr Lisa Studdert, Acting Deputy Secretary, Aged Care and Population Health Group

Mr Charles Wann, First Assistant Secretary, Financial Management Division

Mr Craig Boyd, Chief Financial Officer, Financial Management Division

Mr Nick Henderson, Chief Budget Officer, Financial Management Division

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

Ms Radha Khiani, Acting Assistant Secretary, Ministerial, Governance and Cabinet Branch, People, Communication and Parliamentary Division

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

Ms Donna Moody, First Assistant Secretary, Health Grants and Network

Mr Paul McCormack, Assistant Secretary, Program Advice and Frameworks Branch, Health Grants and Network

Ms Jackie Davis, First Assistant Secretary, Legal and Assurance Division

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

Ms Natasha Cole, First Assistant Secretary, Primary Care and Mental Health Division

Outcome 1

Ms Tania Rishniw, First Assistant Secretary, Portfolio Strategies Division

Ms Moira Campbell, Acting Assistant Secretary, Strategic Policy Branch, Portfolio Strategies Division

Mr Brian Kelleher, Assistant Secretary, Medicare and Aged Care Payments and DHS Relationships

Associate Professor Anne-Marie Boxall, Senior Adviser, Long Term Health Reform Taskforce

Mr Charles Maskell-Knight, Principal Adviser, Long Term Health Reform Taskforce

Dr Nick Hartland, First Assistant Secretary, Health Economics and Research Division

Ms Natasha Cole, First Assistant Secretary, Primary Care and Mental Health Division

Ms Adriana Platona, First Assistant Secretary, Technology Assessment and Access Division

Ms Louise Clarke, Assistant Secretary, Office of Health Technology Assessment – Policy Branch, Technology Assessment and Access Division

Dr Megan Keaney, Principal Medical Adviser, Technology Assessment and Access Division

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

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

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

Ms Bettina McMahon, Chief Operating Officer, Governance and Industry Collaboration and Adoption Division, ADHA

Mr David Delaporte, Chief Financial Officer, Financial Services, Australian Digital Health Agency

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

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

Dr Monica Trujillo, Executive General Manager, Consumer Engagement and Clinical Governance Division, Australian Digital Health Agency

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

Mr Garth McDonald, General Manager, Service Delivery, Innovation and Development Division, Australian Digital Health Agency

Mr Gary Gaffel, Director, Financial Services, Australian Digital Health Agency

Ms Jenny Patton, General Manager, My Health Record Operations, Australian Digital Health Agency

Clinical Professor Meredith Makeham, Chief Medical Adviser, Australian Digital Health Agency

Mr Mark Kinsela, General Manager, Office of the Chief Executive, Australian Digital Health Agency

Outcome 2

Ms Bettina Konti, First Assistant Secretary, Cancer Policy, Screening and Services Taskforce

Ms Alice Creelman, Assistant Secretary, Cancer Policy and Services Branch Cancer Policy, Screening and Services Taskforce

Ms Elizabeth Flynn, Acting First Assistant Secretary, Population Health and Sport Division

Mr David Laffan, Assistant Secretary, Alcohol, Tobacco and Other Drugs Branch, Population Health and Sport Division

Mr Alan Philp, Acting Assistant Secretary, Preventive Health Policy Branch, Population Health and Sport Division

Mr David Hallinan, First Assistant Secretary, Health Workforce Division

Ms Chris Jeacle, Assistant Secretary, Rural Access Branch, Health Workforce Division

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

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

Dr Paul Cutting, Acting Assistant Secretary, Health Workforce Reform Taskforce, Health Workforce Division

Ms Natasha Cole, First Assistant Secretary, Primary Care and Mental Health Division

Ms Emma Wood, Assistant Secretary, Mental Health for Children and Adolescents and Suicide Branch, Primary Care and Mental Health Division

Mr Anthony Millgate, Assistant Secretary, Mental Health Services Branch, Primary Care and Mental Health Division

Ms Janet Quigley, Assistant Secretary, Primary Care, Dental and Palliative Care Branch, Primary Care and Mental Health Division

Mr Chris Bedford, Assistant Secretary, Primary Health Networks Branch, Primary Care and Mental Health Division

Dr Nick Hartland, First Assistant Secretary, Health Economics and Research Division

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

Mr Mark Booth, Chief Executive Officer, Food Standards Australia New Zealand

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

Dr Scott Crerar, General Manager, Science and Risk Assessment, Food Standards Australia New Zealand

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

Mr Shannon White, Chief Executive Officer, National Health Funding Body

Outcome 3

Ms Elizabeth Flynn, 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 Bill Turner, Head, Sports Integrity Review Taskforce, Population Health and Sport Division

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

Ms Kate Palmer, Chief Executive Officer, Australian Sports Commission

Mr Peter Conde, Director, Australian Institute of Sport, Australian Sports Commission

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

Ms Louise Eyres, General Manager, Marketing, Customer Insights and Analytics, Australian Sports Commission

Mr Peter Dunlop, Acting Chief Financial Officer, Corporate Operations, Australian Sports Commission

Mr Robin O'Neill, Executive Director, Strategy and Partnerships, Sport Business and Strategic Partnerships, Australian Sports Commission

Mr David Sharpe, Chief Executive Officer, Australian Sports Anti-Doping Authority

Mr Darren Mullaly, Acting National Manager, Legal and Corporate Services, Australian Sports Anti-Doping Authority

Mr Brian McDonald, National Manager, Operations, Australian Sports Anti-Doping Authority

Outcome 4

Ms Adriana Platona, First Assistant Secretary, Technology Assessment and Access Division

Ms Julianne Quaine, Assistant Secretary, PHI and Pharmacy Branch, Technology Assessment and Access Division

Ms Louise Clarke, Assistant Secretary, Office of Health Technology Assessment – Policy Branch, Technology Assessment and Access Division

Dr Harry Rothenfluh, Assistant Secretary, Office of Health Technology Assessment – Assessment Branch, Technology Assessment and Access Division

Ms Lisa La Rance, Assistant Secretary, Pricing and PBS Policy Branch, Technology Assessment and Access Division

Dr Megan Keaney, Principal Medical Adviser, Technology Assessment and Access Division

Mr David Weiss, First Assistant Secretary, Medical Benefits Division

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

Ms Celia Street, Assistant Secretary, Diagnostic Imaging and Pathology Branch, Medical Benefits Division

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

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

Mr Craig Chalmers, Assistant Secretary, Compliance Targeting Branch, Provider Benefits Integrity Division

Mr Paul Hansen, Acting Assistant Secretary, Compliance Systems Branch, Provider Benefits Integrity Division

Ms Ann Smith, Assistant Secretary, Compliance Operations Branch, Provider Benefits Integrity Division

Ms Tiali Goodchild, Acting Assistant Secretary, Compliance Legislation Taskforce, Provider Benefits Integrity Division

Ms Fiona Buffinton, First Assistant Secretary, In Home Aged Care Division

Mr Nick Morgan, Assistant Secretary, Home Support and Hearing Branch, In Home Aged Care Division

Ms Natasha Cole, First Assistant Secretary, Primary Care and Mental Health Division

Ms Janet Quigley, Assistant Secretary, Primary Care, Dental and Palliative Care Branch, Primary Care and Mental Health Division

Mr Derek Bazen, Director, Primary Care Dental and Palliative Care Branch, Primary Care and Mental Health Division

Mr Charles Maskell-Knight, Principal Adviser, Long Term Health Reform Taskforce

Outcome 5

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

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

Dr Jenny Firman, Principal Medical Advisor, Office of Health Protection

Dr Lucas de Toca, Principal Advisor, Enhanced Response Unit, Office of Health Protection

Ms Sandra Gebbie, Acting Assistant Secretary, Health Emergency Management Branch, Office of Health Protection

Ms Sarah Norris, Acting Assistant Secretary, Health Protection Policy Branch, Office of Health Protection

Dr Masha Somi, Assistant Secretary, Immunisation Branch, Office of Health Protection

Ms Gillian Shaw, Assistant Secretary, Regulatory Policy Branch, Office of Health Protection

Mr Chris Carlile, Assistant Secretary, Enhanced Response Unit, Office of Health Protection

Adjunct Professor Tim Greenaway, Chief Medical Adviser, Health Products Regulation Group

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

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

Ms Tracey Duffy, Acting First Assistant Secretary, Medical Devices and Product Quality Division, Health Products Regulation Group

Ms Nicole McLay, Acting First Assistant Secretary, Regulatory Practice and Support Division, Health Products Regulation Group

Mr George Masri, Assistant Secretary, Regulatory Services and Improvement Branch, Health Products Regulation Group

Dr Raj Bhula, Gene Technology Regulator, Office of the Gene Technology Regulator

Mr Neil Ellis, Executive Director, Regulatory Practice and Compliance Branch, Office of the Gene Technology Regulator

Dr Michael Dornbusch, Assistant Secretary, Evaluation Branch, Office of the Gene Technology Regulator

Outcome 6

Ms Maria Jolly, First Assistant Secretary, Aged Care Reform Taskforce

Ms Amy Laffan, Assistant Secretary, Aged Care Quality and Regulatory Reform Branch, Aged Care Reform Taskforce

Ms Helen Grinbergs, Assistant Secretary, Aged Care Policy Reform Branch, Aged Care Reform Taskforce

Mr Jaye Smith, First Assistant Secretary, Residential and Flexible Aged Care Division

Mr Graeme Barden, Assistant Secretary, Residential and Flexible Care Branch, Residential and Flexible Aged Care Division

Ms Jo Mond, Assistant Secretary, Specialised Programs and Regulation Branch, Residential and Flexible Aged Care Division

Mr Nigel Murray, Assistant Secretary, Funding Policy and Prudential Branch, Residential and Flexible Aged Care Division

Ms Fiona Buffinton, First Assistant Secretary, In Home Aged Care Division

Ms Rachel Goddard, Assistant Secretary, Aged Care Access Branch, In Home Aged Care Division

Mr Travis Haslam, Assistant Secretary, Home Care Branch, In Home Aged Care Division

Mr Nick Morgan, Assistant Secretary, Home Support and Hearing Branch, In Home Aged Care Division

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

Ms Rae Lamb, Australian Aged Care Complaints Commissioner

Mr John Dicer, Aged Care Pricing Commissioner

Committee met at 09:01

CHAIR (Senator Brockman): I declare open this meeting of the Community Affairs Legislation Committee on 29 May 2018. The Senate has referred to the committee the particulars of proposed expenditure for 2018-19 for the portfolios of Health, Social Services and Human Services. The committee may also examine the annual reports of the departments and agencies appearing before it. The committee is due to report to the Senate on 26 June 2018 and has fixed 16 July 2018 as the date for the return of answers to questions taken on notice. Senators are reminded that any written questions on notice should be provided to the committee secretariat by close of business on 8 June 2018.

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 listed on the program. On

Thursday morning at 9 am the committee will move forward to examining the Social Services portfolio, followed at 4.45 pm by the Department of Human Services. On Friday morning at 9 am the committee will resume its examination of the social services portfolio.

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 question going to the operations or financial position of the departments and agencies which are seeking funds in the estimates are relevant questions for the purpose of estimates hearings. I remind officers that the Senate has resolved that there are no areas in connection with the expenditure of public funds where any person has discretion to withhold details or explanations from the parliament or its committees unless the parliament has expressly provided otherwise.

The Senate has resolved also that an officer of a department of the Commonwealth shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude questions asking for explanations of policies or factual questions about when and how policies were adopted.

I particularly draw the attention of witnesses to an order of the Senate of 13 May 2009 specifying the process by which a claim of public interest immunity should be raised. Witnesses are specifically reminded that a statement that information or a document is confidential or consists of advice to government is not a statement that meets the requirements of the 2009 order. Instead witnesses are required to provide some specific indication of the harm to the public interest that could result from the disclosure of the information or the document. I incorporate the public immunity statement.

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)

Department of Health

[09:04]

CHAIR: I welcome Senator the Hon. Bridget McKenzie, representing the Minister for Health; and officers from the Department of Health. Minister, do you have an opening statement?

Senator McKenzie: No, I don't.

CHAIR: Ms Beauchamp?

Ms Beauchamp: No.

CHAIR: In that case, we will get started straightaway. Senator Watt, you have the call.

Senator WATT: Thank you. Welcome, Minister and Ms Beauchamp. I would like to kick off today by talking about five saving measures in the budget. The ones that we were able to identify were $416 million from GP visa changes, $336 million from increased use of generic medicines, $190 million from the MBS review, $78 million from improved use of blood products and anti-rheumatic drugs and $40 million from MedicineWise and the National Return of Unwanted Medicines project. Have I missed any savings measures that were announced in this year's budget, apart from those five?

Ms Beauchamp: I think all of our savings and expenditure measures are listed in Budget Paper No.2. We can go through them line by line, but there are many. I think you have absolutely focused on the more substantial ones, yes.

Senator WATT: We'll get into more detail about those particular savings measures in the relevant outcomes. I just want to talk about it from a global perspective. What is the net saving from those five measures—that is, GP visa changes, increased use of generic medicines, the MBS review, improved use of blood products and anti-rheumatic drugs, MedicineWise and the National Return of Unwanted Medicines project?

Ms Beauchamp: I'll let Mr Wann go through those in details, but one of the things that you have looked at is the MBS review, for example. Any savings from the MBS review has gone back into providing for additional expenses under the MBS. In total, I think there are quite significant increases in MBS expenditure over the forward estimates.

Senator WATT: I'll come to the issue of redeployment of those expenses in a tick.

Ms Beauchamp: Are you just wanting the savings?

Senator WATT: Yes. My calculations work out to over $1 billion in savings from those five measures. Does that sound about right?

Mr Wann: That would be the order of it. We are just trying to work through it. In terms of the visa arrangements, that's actually a Department of Home Affairs measure. It does have an impact on the health portfolio through the MBS and PBS.

Senator WATT: My understanding is that that measure, while it might be introduced by Home Affairs, is going to deliver savings of about $416 million in your department.

Mr Wann: That sounds about right.

Senator WATT: And then $336 million form the generic medicines, $190 million from the MBS review, $78 million from blood products and $40 million from MedicineWise. So all up we are talking about a net saving of over $1 billion.

Mr Wann: That sounds about right.

CHAIR: We have had a request from a photo journalist to take some photos. I assume that the committee is comfortable with that. Information has been provided.

Senator WATT: Sure.

CHAIR: So no documents on the desk et cetera. I'm sure you know the drill.

Senator WATT: Turning to the point you made, Ms Beauchamp, about savings being reinvested, the budget papers do say that the government will reinvest or redirect these savings within the Health portfolio. What exactly does that mean?

Ms Beauchamp: I think when you read the budget papers it is very clear that expenditure over the forward estimates is increasing quite substantially across the whole of the Health, Aged-care and Sport portfolios. So any savings through things like the MBS review or the ones that you have identified have gone back into the provision of additional expenditure items that have been announced in the last budget. When you look at the budget announcements, I think there was an extra $12.4 billion of expenditure across the portfolio, bringing our expenditure for 2018-19 to $99 billion.

Senator WATT: Are you able to point to particular new programs that those savings are being used to support?

Ms Beauchamp: I can go through each of the 90 measures or so that were announced in the budget.

Senator WATT: New measures?

Ms Beauchamp: There were a number of new measures in that. We did provide quite a substantial budget summary to most of our stakeholders so they know exactly what has gone in the budget papers. I am happy to work through those.

Senator WATT: Maybe, for the sake of time, you could take on notice the new programs that are receiving funding from the reinvestment of savings.

Ms Beauchamp: That has all been publicly announced as, obviously, part of the budget process. Budget Paper No.2 and our portfolio budget statements, up the front, has each of the budget measures. But I can certainly provide a summary of new expenditure programs.

Senator WATT: That would be great. At the last estimates, Mr Cormack argued that savings were being reinvested back into the budget bottom line for health. Is that essentially your argument now?

Ms Beauchamp: When you look at the budget process for the portfolio, obviously when you do go through the budget processes—and government makes a lot of decisions across government—the bottom line is that additional money has gone into the portfolio for a number of programs. Indeed, when you look at the whole of government bottom line, there is additional expenditure going into the whole portfolio.

Senator WATT: Isn't it the case, though, that that increase in funding would have happened anyway as a result of population growth and increased service use?

Ms Beauchamp: There are absolutely new expenditure measures aside from changing parameters and population and growth that you have mentioned, yes.

Senator WATT: These new measures and initiatives that are not simply about increased demand for services, what is their total value?

Ms Beauchamp: I would have to take that on notice.

Senator WATT: Would it be more or less than the $1 billion in savings generated?

Ms Beauchamp: When you look at the expenditure, particularly around aged care workforce PBS, it would be much greater than the savings.

Senator WATT: So new measures that weren't in existence last financial year that are now in existence this coming financial year?

Ms Beauchamp: Yes.

Senator WATT: The value of those is higher than the $1 billion you have saved?

Ms Beauchamp: Yes.

Senator WATT: Yes. So you are saying that the increase in funding that is going to your department is not simply a function of increased service use?

Ms Beauchamp: It is a combination of changed parameters plus looking at new expenditure items, yes.

Mr Wann: There are some complications with this particular fiscal update in relation to, for example, the PBS. So in that area there was a change in rebate arrangements which dropped the appropriation quite significantly over the forward estimates. But it also dropped the revenue over the forward estimates. So in terms of net fiscal impacts, it was by and large neutral. But it shows a significant reduction in the appropriation for the PBS going forward.

Senator WATT: So there is actually a reduction in the appropriation, or funding, for the PBS going forward?

Mr Wann: In net terms, no. But in terms of the amount being appropriated by the department, yes.

Senator WATT: That is because some of these savings that you have generated in other measures are being redirected into things like the PBS?

Mr Wann: No. I am not the expert in this area. Under the special pricing arrangements, what used to happen—and we still do this but it is being phased out as a result of this measure—was that the published price was different to the effective price. The difference was returned to us as revenue. In layman's terms, what the measure does is remove, I guess, that flow of cash, and it reduces the amount paid to closer to the effective price, taking out the revenue. I can say that it is artificially dropping the appropriation, but the drop in appropriation is offset by a drop in revenue. So in net terms, the actual amount that is being paid in a real sense is the same. What that does is distorts the appropriation going forward and distorts the health spend going forward.

Senator WATT: Mr Wann, let's say for argument's sake that, due to an increase in demand for services in the coming year, under the existing formula, that would require, let's say, an increase of $1 billion in funding. I have just picked that figure out of the air.

Mr Wann: Sorry, for which program?

Senator WATT: In an overall sense. For the department overall.

Mr Wann: Sorry, yes.

Senator WATT: Let's say because of increased service demand, whether it be through the PBS, the public hospitals or a range of things, the funding required to meet that level of service would increases by $1 billion next financial year. Isn't it the case that these savings that have been generated—these $1 billion in savings—are used to cover some of that increase?

Mr Wann: Yes. Putting aside the issue around the PBS, yes.

Senator WATT: Okay. That is correct. Then the requirement for increased spending in the budget as a whole, across the entire government, is lower because of these savings that are

being used. Savings aren't adding to the amount that is being spent on health. They are helping cover the increased cost that is going to happen anyway.

Mr Wann: It is a combination. Those savings go towards, as per the government's fiscal strategy, paying for policy decisions that result in an increase in expenditure.

Senator WATT: Just to be clear, then, those savings that you have generated are being used to at least partly pay for the increased funding to meet increasing demand for services?

Ms Beauchamp: And new expenditure.

Senator WATT: And new expenditure. That is what I said: at least partly.

Mr Wann: It is principally to pay for new policy measures. For example, the PBS is $1.4 billion in new listings. In the aged care package it is a substantial figure that has to be paid for in workforce and the rural strategy. They are all significant spends. There is a bit less in sport because it is a smaller appropriation. And new Medicare listings; all of those together. The three main packages would be aged care, the PBS listings and workforce. But there are lots of other smaller spends—mental health, Indigenous—

Senator WATT: Yes. We will get into those individual measures in the relevant outcomes. One of the reasons I was asking—and I don't know if you saw this—was because there was an article in the *Australian Financial Review* on May 11 written by Andrew Tillet. I will come to that article more generally soon. But that had a quote from the minister's spokesperson, who said:

> Both Medicare and public hospital funding are activity-based and respond to the number of patients accessing these services…

I took that to mean that they were the primary drivers of increased funding for your department, but is that not the case?

Mr Wann: It is, but there are also past policy decisions—for example, the re-indexation. Again, I am not an expert in this area. You would have to talk to the relevant policy area. But with MBS indexation, for example, it was a staged implementation. I think it was 1 July 2017 and then 2018, 2019 and then 2020. There are new elements to that. The policy changed back at the last budget. They come into effect and then what they do is, at each point, combined with parameter changes and the like, they have an impact on the shape or the profile going forward. For example, the MBS is a very strongly growing program. Its nominal growth is on average 5.2 per cent per year. That is a strong contributor to the overall spend. Similarly, with hospitals and aged care, which is growing on average 6.1 per cent per year. There are other programs that are demand driven, as you say, that are a bit flatter. But by and large, in terms of health overall, it is growing at 3.2 per cent. That is whole of government—health, aged care and sport taken together.

Senator WATT: Well, let's get into some of those increases. I want to take you to an objective measure of the government's claim that health spending is increasing, and that appeared in that article I just referred to by Andrew Tillet in the *Australian Financial Review* on May 11. I have a copy of that here if it is needed. That article quotes from an extensive analysis.

Senator McKenzie: Yes, that would be great.

Senator WATT: Sure. The headline is, 'Poor diagnosis for budget's health spending'. Just so we can keep it going, why don't I pass over the one copy I do have.

Senator McKenzie: I'll meet you halfway.

Senator WATT: Don't make it a habit. You may not do that later in the day. I'm sure you have seen this article and the report that it refers to. The article quotes from an extensive analysis of the budget conducted by experts at the Macquarie University's Centre for the Health Economy. Have you seen that article before?

Mr Wann: Yes.

Senator WATT: You will remember that that report found that growth in health expenditure in this budget was in fact 2.1 per cent compared to 5.1 per cent last year. Is that accurate?

Mr Wann: We do have an area in the department that focuses on these sorts of analytics. They have undertaken an analysis of that. They are probably best placed to speak to it. But, broadly speaking, the department did try to replicate those findings. There were some difficulties—for example, in terms of the use of indexation that they use. It was not what was commonly used. It was difficult to understand what population growth numbers they were using. They did incorporate that issue around that PBS that I referenced previously. They did take account of that so that it wouldn't distort figures with previous periods and forward periods. So they flattened that. We do have the expert in that area. When we tried to run a similar sort of approach in that area, we came to slightly different conclusions to them. We have nominal growth of around 3.8 per cent for the whole of government.

Dr Hartland: Mr Wann is right. We did our own analysis of per capita expenditure by taking population from the ABS, whole of government health expenditure and using CPI as a deflator. We came to a different result to Macquarie University when we did that.

Senator WATT: Right. So what do you say the increase it?

Dr Hartland: When you look at per capita health and aged-care expenditure, and you deflate it with CPI, we are seeing real growth over the forward estimates.

Senator WATT: What is the age?

Dr Hartland: It is just under half a per cent per annum.

Senator WATT: Just under half a per cent per annum real growth across each of the years in the forward estimates?

Dr Hartland: On average.

Senator WATT: Okay.

Mr Wann: That is taken into in population.

Dr Hartland: That is right. That is per capita deflated by CPI.

Senator WATT: So that is not the same as real growth, which in terms of expenditure is just flat?

Mr Wann: That is right.

Senator WATT: And what are the figure if we ask for that?

Mr Wann: I think it is in the order of 1.3 per cent real growth, but per capita brings it down a little bit further.

Dr Hartland: If you just look at growth without per capita and you CPI, you get an average increase of about 1.4 per cent per year.

Senator WATT: You would have seen in that article that the centre's director, Dr Henry Cutler, said that real health expenditure would grow 1 per cent less than the population over the forward estimates, which would mean less money on a per capita basis. Is that accurate?

Dr Hartland: That is not the result we found. These calculations are quite sensitive to all of the three parameters, obviously—so funding data, the population series and the price deflator. We used the ABS series C for population, which we think is the most accurate. If you use other series you can get a different result. And we have used CPI rather than a health price deflator because, as far as we are aware, there is no forecast of health price deflators, so they are a bit unwieldy to use to look at the forward estimate periods. When we use those parameters, we find real growth.

Senator WATT: So you think that that analysis by the Centre for the Health Economy is wrong?

Dr Hartland: We can't verify the parameters he has used.

Ms Beauchamp: The Treasurer has actually set out in Budget Paper No.1 and does mention expenses into the health function, which covers the broad remit of the services I spoke about earlier. It does talk about an increase of 0.4 per cent in real terms from 2018-19 to 2020-21. So we would go with what the Treasurer has identified in here.

Senator WATT: I am asking you as the secretary of the department, though, what you think the answer is?

Ms Beauchamp: The secretary of the department and the department does get involved in whole-of-government issues and we are a contributor to support the government in preparing the budget papers. So we stand by the budget papers.

Senator WATT: Okay. So you are confident that health spending is keeping up with inflation and population?

Ms Beauchamp: That is what the figures show us, yes.

Senator WATT: In that article, Dr Cutler—and he is obviously a pre-eminent health economist—says that service gaps are getting worse and that, if the current trends continue, Australians will either face worse health outcomes or be asked to pay more for their healthcare if the government does not respond. Do you agree with his comments, Ms Beauchamp?

Ms Beauchamp: I think going forward we need to look at the sustainability of the health system and how that is financed overall. I think we will be faced with challenges in the future whilst we have a significant proportion of the budget allocated to health. I'm not in a position to say whether that is right or wrong. It would be hypothesising in terms of what is going to happen in the future.

Senator WATT: One way of dealing with the sustainability of the system is that Australians are asked to pay more for their healthcare.

Ms Beauchamp: There are a number of ways to deal with the sustainability of the health system in terms of financing overall. We have a very good balance between public and private.

Senator WATT: That is nicely avoiding the questions. Are there any proposals currently under consideration that would result in Australians paying more for health services?

Ms Beauchamp: There are currently no proposals under consideration for individuals to pay more.

Senator WATT: For individuals to pay more? I want to get the language right. You are not working on any new proposals that would result in Australians paying more for their healthcare?

Ms Beauchamp: We are not working on any new proposals at the moment, no.

Senator WATT: That is it for this bracket. Senator Singh has some questions and we have some others. I am not sure how you want to divvy up the time.

CHAIR: Senator Di Natale, do you want to take over for a bit?

Senator DI NATALE: Thank you. This might be one for you, Professor Murphy. I suspect you are aware of what is coming, and well done on your performance last night on Four Corners. They were very measured responses.

This is obviously in reference to the recent reporting on out of pocket costs. I want to go to the question of fee transparency. I want to point you to a couple of Senate reports, one of which was a Senate report into out of pocket costs from 2014. Another was in relation to out of pocket costs in 2017. I am intimately familiar with both of those because the 2014 was my referral and I participated in both of those Senate inquiries. The recommendations that came through in both Senate reports was that there needs to be more transparency in the system. As I said, this dates back to 2014. Can you tell me what progress has been made in that area?

Prof. Murphy: I would have to say that the ministerial advisory committee that I am chairing is making very good progress in that space. We have unanimity amongst all the leaders in the medical profession—the AMA, colleges and special societies—that we need a transparency solution that achieves a number of things. One option is that we work out a mechanism to prohibit hidden booking or administrative fees. So no fees should be charged to any patient other than those linked to a clinical service—a Medicare item—and disclosed to Medicare and the private insurer. Patients should be provided with information regarding the costs of their procedure or encounter prior to the first clinical encounter.

One of the challenges we have at the moment is that, if people are provided with financial information once they have had the first consultation, they are locked into a situation where they can't extricate themselves when they find that the fees are not what they expected. So we are working very hard and very collaboratively on a solution. In an ideal world, a general practitioner might be able to refer someone to three or four respected medical specialists and that patient could get access to information about the real impact of out-of-pocket costs and fees before they make a choice of specialist. It is complicated to provide fee information before the first clinical encounter because of the complexity of our private health insurance scheme and the impact of safety nets and the like. We have to make sure that the information provided to consumers will be provided in a form that is understandable and meaningful so that it can help guide choice.

On top of that, the committee is very keen for us to conduct a public relations campaign to inform the community that there is no relationship between price and quality. So, when somebody charges a higher fee, there is no evidence that they provide a higher quality of service. The committee is actively working with every single special medical society at the moment to work on this transparency solution. We intend to work out a way of making that something that every medical specialist would subscribe to. We are due to report back to the minister by the end of the year. I'm hoping we might even finish the work earlier than that. We have a very important meeting of the committee coming up in late June where we will be looking at some serious options for how we provide this transparency solution.

Senator DI NATALE: You mentioned booking fees. I think the President of the Royal Australasian College of Surgeons stated that booking fees were illegal.

Prof. Murphy: They are not illegal under Commonwealth law but they are in breach of the contract that the medical specialist has with the health insurer. Some of those contracts are not very enforceable. But, essentially, when a private insurer agrees with a surgeon or another specialist to have a no gap or known gap arrangement, that specialist agrees to charge no more than a certain fee. On the basis of that, the insurer pays a much higher benefit, sometimes 165 per cent of Medicare, so that the patient has either no gap or only a $500 gap. What these specialists have been doing is charging that agreed maximum fee openly but then charging the patient a booking fee which isn't disclosed to the insurer. So that is breaching their agreement with the private health insurers.

Senator DI NATALE: I know some of my colleagues bemoan this practice. If the practice is in breach of the contract that the surgeon has with private health insurers, what action is being taken to prevent it from happening? It has been going on for years.

Prof. Murphy: The insurers have found it quite difficult because often the consumer won't inform the insurer that it has happened.

Senator DI NATALE: But insurers have known about this for many years.

Prof. Murphy: They have, indeed, and they are very keen to close this gap. As I said, we are hopeful that we will end up with a solution where every medical specialist will commit—

Senator DI NATALE: Hope is one thing. I'm just getting to the issue of what the mechanism is to stop surgeons charging. It is unethical, if it is not an illegal practice. For laypeople, you have the cost of this surgery and then the surgeon will just charge a fee plucked out of god knows where—in addition to the services that they have provided to the patient—that is not covered by Medicare or by the private health insurer.

Prof. Murphy: I agree, Senator. We will end up with a solution that will stop this practice by the end of the year. I can't tell you exactly what that solution will be. It may well be a public commitment, enforceable under consumer law, that the specialist won't be able to charge a fee other than those that are disclosed to Medicare. I don't want to pre-empt the work of my committee, which is looking at a variety of ways of achieving that. The cooperation I have had from the medical leaders has been fantastic and I want to work through with them what will work before we make a public announcement. The minister has been very clear to me that he wants this practice stopped.

Senator DI NATALE: The inquiry back in 2014 recognised this as an issue. It has been going on for many years and it is an open point of debate within the medical community. We

have seen a lot of people downgrade their private health insurance cover as a result of being stung with out-of-pocket costs. It has taken a long time to respond. When was the medical advisory committee established?

Prof. Murphy: We were set up late last year. It came out of the private health insurance reform. I can't remember the exact date, but it was last year. We get together 12 leaders of the medical profession. We have got them together on three occasions so far and we are actually engaged in working on this transparency solution. As I said, I think we will be able to report before the end of this year. It was formed in the second half of last year.

Senator DI NATALE: You said it was a contract, effectively, between the surgeon and the health insurance provider. It is obviously not in the health insurance industry's interest to have this practice continue. Why haven't they taken action?

Prof. Murphy: It's because, in many cases, paradoxically, if the consumer declared that this was happening, the insurer would pay them less because they would only pay them 100 per cent of the Medicare fee. That is because the extra payment is conditional on the surgeon not charging more than the agreed amount. So it is an unusual situation where—

Senator DI NATALE: But then that is a breach of the contract between the surgeon and the health insurance provider.

Prof. Murphy: It is a breach of the contract.

Senator DI NATALE: Why aren't they taking that to—

Prof. Murphy: It's because they have trouble finding out where these breaches have occurred. By very definition, this practice is hidden.

Senator DI NATALE: I am surprised to hear that. I would be interested to look to the ombudsman on this. I would have thought it is one of the major issues in out-of-pocket costs because it is just a fee that is charged at the discretion of the surgeon.

Prof. Murphy: It is an issue. But the insurers have tried to get this information. We are actually engaging in a survey with private health insurers to properly survey a subset of consumers at the moment, just to find out the extent of it. In general, insurers find that the consumers don't report this practice to them. So they have trouble finding out about instances where this has happened. Some of them know that it is happening but they don't know the extent of it. We live in a world of anecdotes in this space, unfortunately.

Senator DI NATALE: I won't labour that point too much. I want to go a bit more to this transparency piece as the centrepiece of the response from the advisory committee. One of the concerns is that if you disclose the fees of all surgeons or service providers—it is not just surgeons—you might create a perverse incentive for people who are charging lower fees to actually raise their fees. Is that something that is being considered? Is that a concern?

Prof. Murphy: It has been raised as a potential issue. At the moment we know that there is pretty good visibility from specialists, especially about what is being charged in their city. I know that, for example, fees among certain speciality groups are higher in some cities than the others. That information is generally known amongst specialists. It is also true that, if consumers are aware that there is no relationship between price and quality, they shop around. We are already seeing instances in some states where people are reducing their fees because they are getting less work. That is a potential issue.

Many of the specialists do have their historical fees included as information in a transparency solution. That would also protect against changing their fees from that point onwards. It is something that that committee has raised as a concern. That is why we are very keen to get that message out there to the public—because one of the biggest challenges, perversely, is this very small proportion of specialists who are charging egregious fees. They are marketing themselves as, 'I am so good; that is why I am so expensive.' So we have to get the message out to the community that we have very good, well-qualified specialists in Australia, most of whom charge only modest and proportionate fees, and that they should avoid those people who claim to provide a better quality service for a substantially higher fee.

Senator DI NATALE: I want to unpack that a bit further. It seems that the focus of the reform is to provide patients with more information, which I think we would all agree would be helpful to some degree. But are you relying on that as the mechanism that will ultimately drive down prices? To me, it seem unlikely that it is going to have the impact that, obviously, the committee hopes for. That is for a few reasons. One is that it is the GP that ultimately refers people on. If you are asking patients to make a decision about their choice of surgeon, my experience, and I think the experience of most GPs, is that patients will say to their GPs, 'Tell me who you think I need to see.' To actually put this in the hands of patients and say, 'You can decide who you want to see,' seems to me unworkable in practice.

Prof. Murphy: No, that is not what I said. What I said was about the model, and many GPs are supporting this model. We absolutely respect the need for the GP to be involved in their choice of specialist, but what we are envisaging is that most GPs would know four or five specialists in a certain area who they believe provide high-quality care. The GP would say to the consumer, 'Here are four or five particular surgeons or proceduralists who can do the thing that I think you need.' In some cases the GP will be happy to help look at the transparency information and find the fee information. Sometimes they will leave it up to the patient. The GP will still provide the gatekeeper function. But in that gatekeeper function they will provide a range of people, such that the patient can use fee information on top of the GP's selection.

Senator DI NATALE: Shouldn't the target of your campaign be GPs then?

Prof. Murphy: We are very much engaging the GPs. The GPs are involved in the discussions and they will be very much part of the solution we provide. Some of the GPs say they don't want to be involved in the fee process. They are happy to make referrals to people on the basis of quality of care. Other GPs say they very much want to be involved and they want the solution that we provide to be able to give them the information so that they can help with the patient's choice. So GPs are definitely involved.

Senator DI NATALE: I suppose my concern—and it was also borne out in the 2014 inquiry into out-of-pocket costs—is that patients are very reluctant to take on a surgeon over cost because they fear it is going to jeopardise their treatment. It might delay their treatment. To put the responsibility on patients is potentially avoiding the bigger problem.

Prof. Murphy: What we are saying is that the patient can have that information before they exercise their choice from the range of specialists that the GP has recommended so they are not in that difficult situation. I agree. Once you have undertaken a clinical encounter and you have a relationship or proceduralist, it is very hard for you to back out. But if you get that

information before you have any relationship then you can make a decision based on fees without it interfering with that relationship or that care because you haven't got a relationship.

Senator DI NATALE: I suppose that goes to the problem where you might have these outliers, these surgeons, who are charging ridiculous fees. They know that they can get away with it. They charge booking fees. We know that it is a very small proportion, but it is obviously a very serious problem. So transparency before the initial consult might, in some instances, particularly if the GP is aware of it, actually do something about that problem. But the big problem that we, again, heard about in both inquiries is what they described last night as 'cumulative bill shock'. That is effectively saying that you can't know the out-of-pocket costs associated with a procedure, particularly if it is a more complex diagnosis that requires ongoing treatment—chronic disease and so on. It is one thing to have an arthroscope in a private hospital. It is another thing if you have a diagnosis of cancer. Breast cancer was the example used last night. It was also the example used in the Senate inquiry. You don't know that there will be a number of procedures—there are pre-op procedures, post-op consults, pathology, imaging and, obviously, an anaesthetic fee. There are a range of ongoing costs associated with a diagnosis and treatment that can't be known, and they all add up. What you have described in terms of knowing the surgeon's fee prior to the consult is not going to deal with that. And that is the bigger problem, isn't it?

Prof. Murphy: Well, no. I think the information that the surgeon will provide will include information about the anaesthetist, the fees that the anaesthetist charges and other associated medical costs with that particular episode. What you are talking about with cancer is quite complicated because cancer treatment is a series of episodes of treatment. So, with breast cancer, you may have primary surgery, you may have chemotherapy, you may have radiotherapy and you may have reconstructive surgery. You are absolutely right. One of the challenges that the committee is working on is that often people, once they start with their first specialist, then get referred on in a chain without the patient having a chance to competitively look at the situation. A good example is radiotherapy. Many people will choose to have primary surgery in the private sector but they may not be made aware of the fact that 60 per cent of radiotherapy is available in the public sector and has no out-of-pocket costs. So those people are not always given a choice.

So, again, the committee is working on having a transparency solution at each stage of that journey. Patients may choose to have private surgery. If they then find the costs of radiotherapy and private chemotherapy unacceptable, there is good access to public services for those things. It is a matter of getting as much information to the consumers as we can and giving them choice at each stage of the journey. We accept that cancer is the most complicated issue because of that multiplicity of services. Some of those outpatient services, the non-admitted services, are covered by the safety net, and there is relief in that. But those complex, multi-admission services are more difficult. What we are focusing on initially are those really egregious ones—for example, the $20,000 prostatectomy, which you heard about last night.

Senator DI NATALE: In terms of some of the other responses, apart from transparency, have you considered any restrictions on providers or is the committee considering any restrictions on providers who charge above a particular range? If not, why not?

Prof. Murphy: Not at this stage. That would be very difficult, constitutionally and legally. But it is possible to consider that. I think the minister's view at the moment is that we should focus very much on improved transparency. We are pleased with the response of the medical profession's leadership to try to address this both internally and through whatever solutions we have. We would prefer to see what happens with a transparency solution before trying to get into the difficult and complex regulatory system of fee regulation, because there are all sorts of definitional issues and constitutional issues that you would have to consider. Those things are possible for the future if this sort of transparency approach doesn't achieve the desired outcomes. I am confident that it will have an impact.

Senator DI NATALE: I suspect it will have an impact on some of those rogue providers. It is not going to do anything about people who have ongoing episodes of care and are faced with a number of out-of-pocket costs which cumulatively will potentially result in tens of thousands of dollars in out-of-pocket costs.

Prof. Murphy: It may if those ongoing episodes of care are subject to the same transparency and contestability, because there are many specialists for people who have limited financial circumstances. They will charge no gap at all, bulk-bill or just charge a very small gap so that they are provided with the choice—

Senator DI NATALE: Who makes that decision?

Prof. Murphy: It is currently the decision of the medical specialist. They make that decision.

Senator DI NATALE: So you are relying on individuals to make a decision—

Prof. Murphy: Yes. Plus, the fact is there is now, certainly in the major cities, an ample supply of most specialists. One of the areas where significant out-of-pocket costs have been a problem is obstetrics. We are already seeing now a significant reduction in fees in some capital cities because of increased competition now that patients are starting to become aware of the fact that price and quality aren't related. So we think competitive pressure will come into play.

Senator DI NATALE: You outlined the example in the cancer treatment space where radiotherapy was an option within the public system. Surely the easiest way to avoid these out-of-pocket costs is to have treatment within the public system? You argument effectively is, 'Well, if people are worried about it, they can go to the public system.'

Prof. Murphy: No, I'm just saying that that is the choice. Everyone has the choice at each stage. Many people would choose to have their surgery done in the private sector because they may get their surgeon of choice and they may feel that that is more important. Some of them may prefer to have private radiotherapy. But radiotherapy is not an admitted procedure and there is good access to public radiotherapy at the moment. So they may choose that. But they may still choose the private sector. What we are keen to do is to make sure that everybody has the full range of information available so that they can choose and so that they are not on a path that is predetermined, from private surgery to private radiotherapy, if they don't have the means to do that.

Senator DI NATALE: But, again, surgeons will make decisions or very strong recommendations to patients based on what they believe is in the patient's interest. You are putting a responsibility back on the patient to say, 'No, you need to push pack against the

surgeon.' We know from all of the evidence we have heard from previous committees—indeed, it was also presented last night—that it is very difficult for patients to push back that worry about what it is going to do in terms of compromising the care that they receive. If the central focus of the reforms is to say that now we are going to leave it to patients—

Prof. Murphy: I think informing patients before they are locked into that situation is really clear. What we would say is that the GP should refer them to four surgeons. They can choose the surgeon. When it comes to radiotherapy, the surgeons would be in a position of saying, 'Here is the private radiotherapy provider I use, but there is a public provider,' and provide that information to patients beforehand so that the culture is that patients are given a choice at each stage. That is what the medical leadership is committed to at the moment.

Senator DI NATALE: Well, it's not happening within the profession.

Prof. Murphy: It is not happening at the moment, but the leadership has to bring about that cultural change across the medical profession. They are committed to doing so. As a medical practitioner you would know the fact that when patients are put in severe financial hardship it—

Senator DI NATALE: For many years.

Prof. Murphy: is very disturbing to many medical practitioners. It is completely unethical in their concept. So the leadership of the medical profession, including the private practice based specialist societies, are very committed to try to make this change.

Senator DI NATALE: Going back to the example of radiotherapy, isn't the problem that we have effectively established a system through the private health insurance industry where we have a set of incentives through the private health insurance rebate and a set of punishments, if you like, through the Medicare levy surcharge that are directing people into private health with the stated intention—as it was stated publicly at the time—of taking pressure off of the public system? Instead of public health care being universal and not being a cost to the consumer, isn't the way we are taking pressure off of the public system just forcing patients to pay more?

Prof. Murphy: Radiotherapy does not have private insurance. It is not an admitted service.

Senator DI NATALE: I am talking generally, though.

Prof. Murphy: Yes. We have a very strong national commitment to a private-public system where people have choice. The consumers, the community, are very much in favour of that mixed private-public system. So that is what we are working within.

Senator DI NATALE: Do you think that the decline, particularly the number of people downgrading the level of their private cover, is a direct consequence of the increasing out-of-pocket costs that people are facing?

Prof. Murphy: It is claimed to be a factor in the surveys of private health consumers, yes. It is one of the factors that they talk about. The most prominent reason is the actual size of the premiums, but the out-of-pocket costs are stated as a factor for people who choose to drop private insurance.

Senator SINGH: I want to go to some of these structural changes to the flexible funds. I particularly want to ask you a little bit about a reply received from the department to a

question on notice from Senator Watt after last estimates. I can give you the number of the particular question. It is SQ17-1443. The question was about providing the total amount allocated to each flexible fund each year from 2013-14 up to 2020-21. In the department's reply, you state:

> Health currently manages its administered appropriation under 'priority areas', rather than the previous structure, which included the former flexible funds. From 1 July 2016, the former flexible funds were redistributed into a new outcome and program structure.

Firstly, who led the change in structure? Was it the department itself that led this change?

Ms Beauchamp: If I understand your question correctly—and it is probably my ignorance in terms of not being in the department in 2014—our expenditure, revenue and budget is governed by what is in the portfolio budget statements under each of the six outcomes. So the six outcomes are a given, and the subprograms are part of that. The government funds programs and initiatives under each of those subprograms in terms of what is in the portfolio budget statements.

Senator SINGH: I acknowledge that you weren't secretary of the department in 2014, but there must be somebody here who can say who led the change in the structure. Was it the department?

Ms Beauchamp: The change in structure would have been determined with the Department of Finance in terms of coming up with an outcome structure that provided more accountability and transparency for parliament in the use of funds across the portfolio.

Senator SINGH: What is your total administered appropriation in 2018-19 and each year across the forward estimates? If it is in the portfolio budget statement you can tell me the page. That would be great.

Ms Beauchamp: I am looking at page 28 and 29 of our portfolio budget statement, which does outline total administered funding and resourcing for the department. On page 29 it talks about total resourcing for 2017-18 and 2018-19 in terms of administered funding.

Senator SINGH: For *Hansard*, can you actually say what that is?

Ms Beauchamp: For 2018-19?

Senator SINGH: Yes.

Ms Beauchamp: It is $68,261,432,000.

Senator SINGH: What about the forwards?

Mr Wann: I actually don't have those figures. I have whole of government. So they are the appropriations for the department. What we do have is the whole-of-government split, which takes into account all of the funding under administered programs going to health, aged care and sport. It would include DVA, DSS, DHS and the portfolio agencies. I can provide you with that number. I would have to take the appropriation to the department on notice.

Ms Beauchamp: We can give you the whole-of-government figure.

Senator SINGH: I am actually asking at the moment about the flexible funds. But go ahead with what you do have.

Mr Wann: In terms of health, aged care and sport, the total allocation in terms of administered funding in 2018-19 is $99,055,000,000. For 2019-20 it is $101,888,000,000. For 2020-21 it is $104,565,000. For 2021-22 it is $108,976,000.

Senator SINGH: Where in this portfolio budget statement are these new priority areas outlined that you have subsumed the flexible funds into, because I cannot find them?

Mr Wann: At this level it goes to sub-outcome level and then under the sub-outcomes are the priorities. If we go to outcome 1, for example—

Senator SINGH: What I am trying to find here is where each of the flexible funds are now hidden. In your response to Senator Watt at last estimates, you said, 'Health currently manages its administered appropriation under "priority areas".' You put that in inverted commas. So there is some kind of change of structure. You talked about the 'previous structure, which included the former flexible funds'. Now we have this new structure. I am trying to understand this new structure and where I can find the flexible funds in these new priority areas.

Mr Wann: If you go to the examples on page 59 and look at outcome 2, that is probably relevant in this context. You will see the various programs listed under outcome 2. So program 2.1, mental health; program 2.2, Aboriginal and Torres Strait Islander health, and so on. Within that, we then have priorities. That splits those programs into lower levels of reporting.

Senator SINGH: How many priority areas are there and what are all of these priority areas?

Mr Wann: There are 200 priority areas.

Senator SINGH: Right. Can we get some kind of list of what they all are?

Mr Wann: Yes, absolutely.

Senator SINGH: Do you have to take that on notice or can that be tabled to the committee?

Mr Wann: We will take it on notice, but we can get it to you very quickly.

Ms Beauchamp: But it is set out in the budget papers.

Senator SINGH: Can you show me where?

Ms Beauchamp: I think Mr Wann spoke about page 59 and the programs in each of outcome 2.

Senator SINGH: But which are the priority areas?

Ms Beauchamp: All of the priority areas are listed here under—

Senator SINGH: There are seven priority areas there; is that what you are saying—from 2.1 to 2.7? Are they priority areas?

Ms Beauchamp: No, under each of those program areas there are subprograms, which represent the priority areas.

Senator SINGH: Right. And where are those subprograms?

Mr Wann: They are at a lower level of reporting that is not reported in—

Senator SINGH: So they are not in the portfolio budget statement?

Mr Wann: No, but we can get you a list of them.

Senator SINGH: Why aren't they in the portfolio budget statement?

Mr Wann: Because the standards for the portfolio budget statement don't require that sort of reporting.

Senator SINGH: So the flexible funds are no longer identified in the budget. Is that what you are saying?

Mr Wann: They are grouped into those—

Senator SINGH: They are grouped into those priority areas which are not in the budget statement.

Mr Wann: You are absolutely correct. It doesn't go down to that level of detail.

Senator SINGH: Isn't that an issue of transparency? You have created this new structure. The flexible funds are no longer kind of flexible funds. They are not being subsumed into these priority areas. You have told me there are 200 priority areas, none of which are listed in the portfolio budget statement—and which we still don't have a list of. You have had to take that on notice. It seems to me that the flexible funds have been completely hidden by this government.

Mr Wann: When it comes to the relevant outcome, you are in a position to ask questions about the detail under each of those programs and how those are mapped across. We are able to provide you with a list of those priority areas. We can do that quite quickly. Not instantaneously, but certainly later today we can get you that list.

Senator SINGH: Well, they are hardly priority areas if you don't have a list of your priority areas available to us right now. Anyway, let's go on. We are going to have to dig down a bit into this, and I am hoping it won't all have to be taken on notice. How much funding of each of these priority areas is committed?

Mr Wann: We would be able to provide that. There is reporting underneath priority areas and you can go all the way down to cost centre level. It is, I guess, the way that is most appropriate in terms of a management and in a performance reporting sense. And the portfolio budget statement certainly stipulates that this is the level that is appropriate to report at.

Senator SINGH: Okay, but these priority areas, you are saying, have funding committed to them and yet they are not in the budget statement.

Ms Beauchamp: Just as an example, one of the funding items was 'practice incentives for general practice'. That certainly is identified clearly as a separate line item under program 2.6, with an allocation of funding provided there over the forward estimates. And it is clear to see on page 64, for example, around primary care practice incentives, where we have primary health care quality and coordination. This budget articulates, perhaps, a different way of presenting the information. I don't think—

Senator SINGH: It certainly does.

Ms Beauchamp: it is around a lack of transparency. It is absolutely transparent. Perhaps it might be easier to map exactly these funding items that would have been seen under the flexible fund into where they appear in the budget papers. I just gave you an example of one of them, which was the practice incentives for general practice, which is clearly highlighted on page 64.

Senator SINGH: It is not highlighted as a priority area. How do I know that that is one of the 200 priority areas? It doesn't say it.

Ms Beauchamp: Sorry, it is highlighted as a separate line item in the budget papers.

Senator SINGH: It doesn't say it is a priority area.

Mr Wann: No.

Senator SINGH: The question by Senator Watt at the last senate estimates was in relation to the flexible funds and where forward spending was on those from 2013-14 to 2020-21. Your response was that they have now been administered under 'priority areas'. I am now asking you where those priority areas are, because I can't find them in the budget papers and neither can you. And you are telling me that it is transparent. It is not transparent, Ms Beauchamp, because it is not there.

Ms Beauchamp: Sorry, these are the priority areas. One of them I just highlighted.

Senator SINGH: How is anyone else supposed to know that? You know that.

Ms Beauchamp: Just to pick up another one, in terms of Indigenous health funding, the Indigenous Australians' Health Program is absolutely identified as a priority area.

Senator SINGH: Could you show me where? Where does it say that it is a priority area?

Ms Beauchamp: As I said, I will map those flexible funds to exactly where they appear in the budget papers for you.

Senator SINGH: Okay, I would appreciate that.

Senator WATT: There are no consolidated budget papers, though.

Mr Wann: No, not in that one.

Senator SINGH: On those flexible funds.

CHAIR: Can I just ask a question to clarify? My understanding from past history is that Finance set the parameters for what needs to be in the portfolio budget statement.

Mr Wann: That is exactly right, and this is the level and the structure that has been agreed to and approved by Finance. There are rules, obviously, around what you can do with money once it is in the program structure, and limitations on moving money between programs and certainly between outcomes. The lower you get, the greater flexibility there is to move money around within those programs. So it improves in terms of resource allocation and ensures that we have resources where they are required. But at this portfolio budget statement level, there are some hard barriers that you have to adhere to. You have to seek approval either through government or the Minister of Finance or advise Finance if you are going to make changes to the reporting that is made at the portfolio budget statement level.

Senator SINGH: Ms Beauchamp, how much of the funding is allocated in each of these 200 priority areas each year of the forward estimates?

Mr Wann: Most of them will be in bill No. 1, but we can take that on notice and get back to you with an answer.

Ms Beauchamp: Probably the best way to do it is to give you the forward estimates for each of the subprograms, which are the priority areas—that is, mental health, Aboriginal and Torres Strait Islander health, health workforce and those sorts of priority areas.

Senator SINGH: We would like the whole 200 on notice, if you are going to do this. Thanks. Also, how much is contracted and committed and how much is uncommitted?

Ms Beauchamp: That is a completely new question.

Senator SINGH: Yes.

Ms Beauchamp: The subprograms, if I can just confirm, are absolutely outlined in the portfolio budget statements and there is funding for 2017-18—estimated, actual and each of the forward estimates. For example—

Senator SINGH: Excuse me, Ms Beauchamp, are you saying that the subprograms are the same as the priority areas?

Ms Beauchamp: I think that the subprograms are probably the best way to look at it in terms of priority areas.

Senator SINGH: I am asking you: are the subprograms the same as the 200 priority areas?

Ms Beauchamp: Not exactly, no. There is a further level of detail beneath those subprograms. I am trying to make it easier so you can map it exactly to the budget papers. So, yes, we will get that information for you. You have asked for committed and contracted funding. When you have the number of program areas we have, and I think over 9,800 different contract areas, then it is a big job to look at committed and contracted funds. Of course, those contracted funding amounts change over time as contracts are entered into and renewed and the like. So I will absolutely have to take that on notice.

Mr Wann: They would change almost on a daily basis—the level of commitments and pre-commitments.

Senator WATT: Let's just go with, as of today. If you could take that on notice.

Ms Beauchamp: As of today. We will get you the committed and contracted under each of the subprograms.

Senator WATT: We would also like it broken down into the 200 priority areas. We want to get into that level of detail.

Ms Beauchamp: I just want to make sure that we can manage that. It is a hugely busy portfolio. I will look at what information is available, confirm the number of subprograms and the level of detail and provide what is committed and contracted for each of those, without getting in the way of delivering on all of the budget initiatives that we have in front of us.

Mr Wann: To take a point in time would require quite a large exercise. We couldn't provide something of that detail today. But we will see what is involved and get back to you.

Senator SINGH: Do you think it is acceptable, Ms Beauchamp, that you can't tell the parliament where your administered appropriations are going?

Ms Beauchamp: I think it is very clearly set out in our portfolio budget statement. When I spoke about $99 billion per annum by subprogram, that is identified in each of those areas. The flexible funds, which I think you have been referring to, are a very minor proportion of that $99 billion per annum. I think you are talking about $2 billion worth of funding under the flexible fund.

Senator SINGH: So you think that $2 billion is minor?

Ms Beauchamp: I think it is a small proportion of the $99 billion per annum. The government has clearly set out where our administered funding and our departmental funding

goes. I just want to make sure that we can provide that level of detail that you are looking for. The problem is that we have, I think, over 760 individual programs across the whole portfolio. When you are looking at the number of contracts and committed within that, it is a very large piece of work to do.

Senator SINGH: Well, let's try to get back to the detail of the flexible fund. You would recall then that in the 2014 budget, the 2015 budget and the2016 budget there was a combined cut of $975.5 million to the former flexible funds. $104.2 million of those savings were budgeted in 2015-16 when the former flexible funds were still in place. Were those savings achieved?

Ms Beauchamp: I would have to take that on notice.

Senator SINGH: Okay. Can you also then give us a breakdown of which flexible funds, as they stood then, those savings came from?

Mr Wann: Those savings would have been achieved as a matter of course, in terms of the money was taken out of the appropriation. Are you asking in what way that was given effect?

Senator SINGH: Yes. To the flexible funds.

Mr Wann: The flexible funds don't exist.

Senator SINGH: As they stood at that time when they did exist.

Mr Wann: Back in 2015-16?

Senator SINGH: Yes.

Mr Wann: Okay. We will definitely have to take that on notice.

Senator SINGH: The remaining $870.9 million of cuts were budgeted for 2016-17 to 2019-20. That is, after the new priority areas were put in place. Can you confirm that these savings will be achieved from the new priority areas?

Mr Wann: Again, in one sense they have already been achieved because they have been taken out of the appropriation. In terms of the nature of the programs and the way that has been given effect, that would vary from program to program. With the priority structure and the programs, the way they are shaped underneath that, that would be almost an outcome by outcome proposition. Generally, the first two outcomes would be where a lot of them would be. The program owners would have to work through how that was given effect.

CHAIR: Can I just jump in there, Senator Singh? Minister, can I just confirm that the government's policy remains that any savings made in the health portfolio are re-invested in the health portfolio?

Senator McKenzie: Absolutely.

CHAIR: Thank you.

Senator SINGH: If you could give us a breakdown of the cuts by year and priority area on notice, that would be appreciated.

Mr Wann: Noting that those cuts have already been made and used as offsets, I guess, against other spends. So those cuts have already been taken out of the forward estimates. So, again, I guess the question is that you want to know if that has been give effect. The cuts have already happened and it is giving effect to that.

Ms Beauchamp: The difficulty will be that there has been, I think, three budgets since then. There would be ons and offs within each of our subprograms that I talked about. So it would be very hard to map what has happened other than, as Mr Wann says, the budget savings would have been taken some time ago. But there have been a number of initiatives, and three budgets worth of initiatives, that have impacted on each of those programs and subprograms.

Senator SINGH: The question was if you could take on notice the cuts by priority area.

Ms Beauchamp: Sorry, when you say, 'by priority area', do you mean for flexible funds allocated in 2015-16 or the current priority areas?

Senator SINGH: No, that was not the question. That was the previous question. My question just now was in relation to the 2016-17 to 2019-20 budget cuts. That is the remaining $870.9 million. I asked if you could confirm whether these savings will be achieved from the new priority areas and a breakdown of that amount—that cut—by year and by priority area.

Mr Wann: Again, I will just say, though, that the cuts have already been achieved. They have been taken out of the appropriation.

Senator SINGH: In 2015-16?

Mr Wann: In 2015-16.

Senator SINGH: I thought the remaining $870.9 million was budgeted for 2016-17 to 2019-20. Has that already been cut?

Mr Wann: Yes, back with the original decision.

Senator SINGH: Okay.

CHAIR: Are you going to change topic here, Senator Singh?

Senator SINGH: No, it is still flexible funds.

CHAIR: I will throw the call elsewhere if—

Senator SINGH: No, it is still the same topic.

CHAIR: Okay.

Senator SINGH: I want to ask about flexible funds in relation to services in north-west Tasmania and whether those services were quarantined from cuts to the flexible funds. That includes the $197.1 million cut in 2014-15, the $962.8 in the 2015-16 budget—which included cuts to, obviously, the flexible fund—and the $182.2 million cut in the 2016-17 budget. Was there any quarantining of services in north-west Tasmania?

Mr Wann: I think we would have to take that on notice.

Senator SINGH: I am particularly interested in the government's cuts to the TAZREACH program. You would be aware that the TAZREACH program is a vital program in north-west Tasmania and can be the difference between someone getting the care they need or missing out altogether. The cuts to this program are really important to the north-west of Tasmania. I would like to know whether those cuts to TAZREACH were the result of the 2015 budget decision. Do you have to take that on notice as well?

Mr Wann: Yes, I think we do.

Ms Beauchamp: I have just asked to see if I can get the officers here that are responsible for that program.

Senator SINGH: Okay, great. My question is in relation to the TAZREACH program and whether the cuts to that program were a result of the 2015 budget decision?

CHAIR: Sorry, just before you answer, Mr Hallinan, we are happy to be flexible in the cross-portfolio section, but if we start getting into really specific program details for other areas—

Senator SINGH: It is still budget cuts.

CHAIR: Okay.

Mr Hallinan: The TAZREACH program was rolled out as an element of the then medical specialist outreach assistance program. That was an outreach program across the country. It was established through a 2012 commitment by the then government but was scheduled to terminate in June 2016, which is when it terminated.

Senator SINGH: Were the cuts were a result of the 2015 budget decision?

Mr Hallinan: No. My understanding of that program was that it was scheduled to terminate, as a terminating measure, in June 2016, which is why the funding for it discontinued at that stage. But that does go back a couple of years now, so I can take the details on notice and confirm that for you, if you like.

Senator SINGH: Okay. It was reported in June 2016 that the funding to TAZREACH was reduced by $2.5 million by the West Coast Council mayor. Are you aware of that?

Mr Hallinan: It would be in that order, yes.

Senator SINGH: It would be in the order of $2.5 million?

Mr Hallinan: The additional funding that was committed in the period between 2012 and 2016 was $1,021,000 in 2013-14, $1,564,000 in 2014-15 and $2,392,000 in 2015-16. That additional funding ceased in June 2016 in accordance, I think, with the original measure from 2012. But I will take that on notice and confirm it following the hearing. There is still funding going into outreach activities in Tasmania through the rural health outreach fund. I think it is in the order of $1 million to $2 million per annum. Again, I can take that on notice.

Senator SINGH: Okay. What did this reduction mean for outreach services on the north-west coast of Tasmania?

Mr Hallinan: I would have to take that on notice. It did cease almost two years ago now, so it is not something that I have detailed information on with me.

Senator SINGH: Okay. I just refer to the West Coast Council mayor, Phil Vickers, who said,

> The loss of these services places more stress on unwell residents and will also place more pressure on these services in other regions as West Coasters will now have to travel to attend appointments.

So it was clearly reported by the mayor that the reduction in funding of this program has had an impact in the region. Are you saying that you are not aware of that?

Mr Hallinan: It certainly would have led to a reduction of outreach services in that region.

Senator SINGH: You are confirming that? Okay.

Mr Hallinan: Yes, but I don't have the details of what those would have been.

Senator SINGH: What services were previously offered by TAZREACH that are no longer available because of this reduction?

CHAIR: This is really getting into the weeds of a particular policy. I accept that these are legitimate questions, Senator Singh, but we are really outside of cross-portfolio. We can carry these questions over to when we have the health workforce on. Health workforce is not that far away.

Senator SINGH: I don't have any more, other than one question, so we could knock it over.

CHAIR: All right. I'll let you ask the question. Let's knock it over.

Mr Hallinan: I can take that on notice for you, Senator.

Senator SINGH: And also any jobs lost in the health sector workforce as a result of this reduction.

Senator McKenzie: Is that staff data?

Mr Hallinan: I don't think we'd be able to provide a response to that one. It's not information that we track.

Senator SINGH: You don't track job losses?

Mr Hallinan: An outreach program is, by its nature, taking somebody from an area and moving them to another area for the delivery of services in that location. They're usually employed in a home town, wherever that might be—it could be Hobart; it could be Melbourne—and they'll be sent out to provide an outreach service for a short period of time in the community. I don't imagine there would have been any major job losses associated with the terminating of that outreach arrangement, because they are, by their nature, employed in the location they usually live or reside.

Senator SINGH: Are you taking that on notice?

Mr Hallinan: No. I don't think I'll have information on jobs associated with those programs.

Senator SINGH: Okay.

Mr Wann: By way of clarification—and I guess this comes from not being a long-term Health person—we do have a mapping of flexible funds to programs, so that will be helpful in terms of the architecture. Also, I might have given the wrong impression. Flexible funds were not previously reported in portfolio budget statements at that level. They were a level underneath the PB statements. They're actually at a similar level. Neither the priority areas nor flexible funds were reported in the portfolio budget statements.

Senator SINGH: Mr Wann, are you able to table that page that you have?

Mr Wann: Absolutely.

Senator SINGH: Thank you.

Senator RICE: I want to start by asking about your department's implementation of the Australian Government Guidelines on the Recognition of Sex and Gender, which allow for record keeping to record genders other than male or female on databases and forms, and which support respectful relationships between gender-diverse, transgender and intersex

people. The guidelines were meant to have been fully implemented by July 2016, but I'm aware that not all departments have done that implementation, so I want to know what steps the department has taken to implement the guidelines.

Ms Balmanno: We implemented the guidelines in the early part of the 2016-17 financial year. We included a non-binary gender option within our HR systems. We've also implemented e-learning modules within the department, which we encourage staff to undertake so they better understand the experiences of LGBTI people. And we're currently working with our LGBTI staff network to develop an LGBTI action plan.

Senator RICE: Is the e-learning available for people to undertake?

Ms Balmanno: Yes, it's available for all staff to undertake.

Senator RICE: Is there any mandatory training?

Ms Balmanno: Not at this stage, no.

Senator RICE: Do you track how many staff undertake that training?

Ms Balmanno: Yes, we can track that. I don't have that data with me.

Senator RICE: If you could take that on notice, that would be good. Does the department have outward-facing operations—that is, interactions with members of the public?

Ms Balmanno: Yes.

Mr McCabe: Yes, we do. One example is the My Aged Care system.

Senator RICE: And how have the guidelines been implemented in terms of your outward-facing operations—your dealings with the public?

Mr McCabe: We'd have to take that on notice to provide a detailed response, but specific to the system I mentioned, we have implemented additional fields for clients to add additional information regarding gender diversity.

Senator RICE: What training has been provided to people who are dealing with members of the public to encourage respectful relationships?

Ms Balmanno: We would have to take that on notice. Colleagues in the aged-care part of the portfolio may be able to answer.

Ms Beauchamp: And also, through our contracted providers through the Department of Human Services, I'll just confirm with them exactly what they're doing as well.

Senator RICE: Are there other programs like the My Aged Care that the department runs that also would be relevant, that the guidelines should have been implemented through?

Ms Balmanno: Most of our other systems that are externally facing or capture personal data in that way and are not run by the department. They're administered, for example, by the Department of Human Services.

Senator RICE: How about the various agencies that fall within the department? Do you track whether those agencies have implemented the guidelines?

Mr McCabe: No, we don't. That would be something we'd have to look at specifically.

Ms Balmanno: We do routinely share our approaches and our policies where we implement new training options. When a new HR policy or guideline starts, for example, we

routinely make those available to the portfolio agencies so they can utilise that same information.

Senator RICE: Right. But you don't track whether they are actually—?

Ms Balmanno: No.

Senator RICE: Would those agencies be where most of the outward-facing operations occur that the department's responsible for?

Ms Balmanno: Some agencies are outward-facing; some are not.

Senator RICE: Right. But there would be considerable outward-facing interactions with the community through those agencies?

Mr McCabe: The MyHealth record would be a good example with the Australian Digital Health Agency.

Senator RICE: Do you know, for example, whether they have fully implemented the guidelines?

Mr McCabe: I don't, off the top of my head, but we could ask them.

Senator RICE: Could you take on notice what you know about how well the various agencies that fall within the department have implemented the guidelines?

Mr McCabe: Yes.

Senator RICE: My second lot of questions is with regard to support for intersex organisations. There was a Senate inquiry into the involuntary or coerced sterilisation of intersex people in Australia. One of the recommendations for that inquiry was:

> The committee recommends that the provision of information about intersex support groups to both parents/families and the patient be a mandatory part of the health care management of intersex cases.

So I want to know whether there is any federal funding given to intersex-led support groups.

Mr McCabe: We're not aware, specifically within our portfolio, of any funding or arrangements.

Senator RICE: So you'll have to take that on notice. I did ask a question in October estimates last year about funding for intersex peer-support services. The information I got back was that the department funded QLife, MindOUT!, ReachOUT and Qheadspace. Do you agree that none of these organisations, despite all the very good work that they do, are in fact intersex peer-support organisations?

Ms Beauchamp: We don't do anything around intersex peer-support organisations, but we do provide services, particularly through mental health, for the ones that you just mentioned.

Senator RICE: Given that Senate inquiry recommended that there should be mandatory connection with intersex support groups, is there any reason or has consideration ever been given to supporting intersex peer-support organisations, or any reason why there is no federal funding for these organisations?

Ms Beauchamp: I think that's really an issue that we'll have to address across a number of portfolios, but I can certainly take it on notice from a health portfolio perspective.

Senator RICE: I'm told that it would be through the health portfolio perspective. If there was funding to be available for intersex support organisations, it would be through Health,

particularly given the ongoing issue of involuntary and coerced sterilisation of intersex babies and infants—

Ms Beauchamp: I'll take that on notice.

Senator RICE: and whether the department has got any plans to ensure the wellbeing of the intersex population.

Senator WATT: Ms Beauchamp, in relation to the 2018-19 budget, can the department confirm if any funding from other health outcomes went to outcome 6, Aged Care?

Mr Wann: In some of the packages, funding might have been appropriated to a various number of outcomes. For example, in the aged-care package there would have been some measures that were directed to other outcomes coming out of, for example, outcome 2 in the context of mental health. That would have been part of the ageing package.

Senator WATT: As an example, then: money has been shifted from Outcome 2, which is mental health, to aged care?

Mr Wann: No, the funding has gone to the respective outcomes. It's more the fact that, in terms of packaging, the target group for this particular measure is more in the aged end of the spectrum. It would form part of the ageing package, but it would be funded out of outcome 2.

Senator WATT: Right. So the funding that's been allocated and announced for the ageing package includes funding that is actually provided to other outcomes such as mental health?

Mr Wann: Yes, that's correct.

Senator WATT: Are there any other examples of funding in other outcomes that have been rolled into this ageing package?

Mr Wann: That's probably the biggest one. On page 32 on the Portfolio Budget Statements you see the package 'More Choices for a Longer Life'. It lists the various outcomes and programs against which funding has been provided.

Senator WATT: I see. For instance, money's come out of outcomes 2.1, 2.2 and 2.4 and has been moved across to this or rolled into this ageing package?

Mr Wann: Rolled into the ageing package; that's correct.

Senator WATT: Okay. And so 2.1 is mental health. 2.2 is—

Mr Wann: Indigenous, so Aboriginal and Torres Strait Islander health. 2.3 is health workforce. I think they're the only ones.

Senator WATT: 2.4 is listed as well, which is—

Mr Wann: 2.4 is preventative health disease support.

Senator WATT: Is any of that funding that's listed on page 32 new funding?

Mr Wann: Yes. This represents the change in funding for these particular outcomes and programs.

Senator WATT: It's not new funding for your department; it's new funding for ageing which has come from other parts of the department?

Mr Wann: No, each of these programs receives additional funding, so 2.1 in 2018-19 would receive $8½ million, 2.4 would receive $2.4 million and so on. So they do get additional funding.

Senator WATT: It's not that money that was already allocated to, for instance, outcome 2.1 has been shifted across to outcome 6?

Mr Wann: No.

Ms Beauchamp: In this table these are the net changes in the budget, so these are new figures. If there was a reallocation, it would probably have zero or a dash or something like that, but these are actually new numbers.

Senator WATT: Okay. Can you confirm whether there were any additional funds outside of the Health portfolio that went to outcome 6? Would it be these ones that we're talking about here? For instance, are there any funds from consolidated revenue—new funds—that went to outcome 6?

Mr Wann: In one sense, this shows the shift between consolidated revenue and into our appropriation both ways. So, if it's a positive figure, it's new money going into that outcome and program. If it's in brackets, it's going the other way.

Senator WATT: Okay. Obviously tomorrow we'll have a long time allocated to aged care in detail, but can the department confirm whether there was any funding reallocated from other areas within the ageing or Aged-Care portfolio?

There's been plenty of media about funding being reallocated from residential aged care towards the home care packages.

Mr Wann: Are you asking if there have been savings within that? We don't hypothecate in that sense, but you can see the net impact on the overall appropriations outlined on page 32.

Senator WATT: But it is the case that funding, for instance, was taken from residential aged care to help pay for the increase in home care packages.

Mr Wann: That's a slightly different matter. What happened in that instance is that you had two separate programs that were separately appropriated. Lisa's probably better placed to talk about the policy, but a policy decision was taken to combine those to provide flexibility. The intent of the new program was so that you can flexibly move money to where the demand for resi care or home care is. That's different to making a decision that reduces or increases either.

Senator McKenzie: In the previous government, Labor banked the savings out of aged care whereas we've made the conscious decision to retain all those savings within the Aged Care portfolio.

Senator WATT: Was there any new money for the new home care packages?

Ms Beauchamp: Yes. There's been money allocated for 14,000 new home care packages.

Senator WATT: My question was about new money as opposed to the money that was previously allocated to residential aged care.

Mr Wann: In the sense that the two appropriations have come together, that there's been a shift in funding from one area of less growth and demand to an area of greater growth and demand, yes, that's happened within that new program.

Senator WATT: Yes, but it's not new funding for aged care. You used to have funding for residential aged care in this bucket and you had funding for home care packages in that

bucket. What you've said has happened is that they've been collapsed into one bucket so that the money can be used flexibly.

Mr Wann: Yes.

Senator WATT: My question was whether there was any new funding that wasn't in those buckets that has been put in to help pay for these home care packages.

Mr Wann: Funding had to be provided for the additional home care packages and, within this new program, there was a reduced growth in demand for residential care. That funding that would've normally gone there has shifted across within this new program.

Senator WATT: I'm very, very clear on that. What I'm getting at is that there was no new funding that wasn't already going to aged care that has been provided to pay for more home care packages. It's all come from existing resources that were spent otherwise.

Mr Wann: Yes. Resources were identified in the forward estimates for residential care, but the level of demand isn't as great, so, with the new program, yes, that funding has been reallocated.

Senator WATT: Aside from residential aged care, are there other existing funds in the ageing portfolio that have been redirected to help pay for the new home care packages?

Mr Wann: No.

CHAIR: Can I seek clarification here? My understanding is that all savings that the government has made in the Health portfolio have been reinvested back into the Health portfolio. That would include the aged care portion of the Health portfolio. Is it correct, Minister, that all savings have been reinvested?

Senator McKENZIE: Yes. Absolutely.

CHAIR: Can we compare that, then, with what happened under previous governments? Do we have any examples where that wasn't the case?

Senator McKenzie: My understanding is that the previous Labor government took savings out of aged care specifically and banked them rather than reinvesting in aged care packages.

Ms Beauchamp: I will also confirm that, in terms of the budget paper, there's a net increase in money going to aged care. I think Mr Wann was describing it as rather than looking at estimates variations and the like, we now have a much more flexible pool that is kept within the aged-care system and not lost to other parts of the budget. So not only has there been a net increase, but we now have a flexible pool to manage those priorities, and hence the allocations of 20,000 new places.

Senator WATT: I understand that. What I think we've been able to establish is that there is additional funding being provided to provide new Home Care Packages.

Ms Beauchamp: That's correct.

Senator WATT: That funding has come from reductions in funding to the residential aged-care sector?

Ms Beauchamp: No. There's been a collapsing of the two programs.

Senator WATT: Another word for redirecting.

Ms Beauchamp: In the past, I think any estimates variations would have been returned to consolidated revenue. Now, that money is being reinvested into new packages. I think the budget papers show, and our budget papers show, a net increase in aged-care funding.

Senator WATT: But not for the Home Care Packages?

Ms Beauchamp: I think across both the programs now there's a net increase.

Senator WATT: Yes, but not for the Home Care Packages. I don't think I could be any clearer that you have collapsed previous funding buckets. We've heard that several times. I get that. What I'm trying to establish is, is it the case that no new funding, aside from the money that was already there for residential aged care—that was never in your portfolio before—has been provided to pay for the new Home Care Packages?

Ms Beauchamp: There is new funding for the aged care Home Care Packages.

Senator WATT: Can you point to that for me in the budget papers?

Ms Beauchamp: There are 14,000 new Home Care Packages.

Senator WATT: I know that. How's it being funded?

Ms Beauchamp: Through the budget.

Senator WATT: By collapsing the two previous funding buckets into one?

Ms Beauchamp: I think that's one element, but I also mentioned that there'd been a net increase in appropriation to aged care.

Senator WATT: I understand that, but that's different thing to the home funding Home Care Packages.

Senator McKenzie: I think it's useful to unpack it—

Senator WATT: It's been unpacked. We've been unpacking it for the last 10 minutes.

Senator McKenzie: so you get a full picture of how we're able to provide such a comprehensive aged-care package.

CHAIR: I think we've been unpacking it so much the box is empty!

Senator McKenzie: They'll be nothing left for tomorrow—

Senator WATT: In terms of these decisions, which minister made the decisions around funding allocations in outcome 6?

Ms Beauchamp: The government made the decision through the budget process.

Senator WATT: And which minister?

Ms Beauchamp: It's a collective decision of cabinet.

Senator WATT: So which minister put forward these proposals to cabinet?

Ms Beauchamp: A number of ministers put forward the proposals through a task force.

Senator WATT: Minister Hunt?

Ms Beauchamp: He was one of the ministers.

Senator SINGH: Can you list the ministers?

Ms Beauchamp: I think there was a ministerial task force across Minister Wyatt, Minister McKenzie, Minister Hunt, the Treasurer—

Senator McKenzie: Mr Tehan—so a range of ministers were involved.

Senator WATT: The ultimate decision about which aspect of the aged care portfolio received this money, which minister made those decisions? Which minister decided this type of aged care gets this and this type of aged care gets that? Was there an individual minister, who ultimately—

Ms Beauchamp: I think it was a decision of budget and cabinet collectively.

Senator WATT: In terms of other non-budget measures across the ageing and aged care portfolios which minister makes those decisions?

Ms Beauchamp: Again, I mentioned a ministerial task force, and it was the collective decision of cabinet and the Expenditure Review Committee on how funds were allocated.

Senator WATT: Leaving aside the Aged Care Packages, for non-budget matters within the portfolio, which minister makes those decisions?

Ms Beauchamp: Could you give an example of a non-budget measure?

Senator WATT: I've never worked in this portfolio, but you have so I might need to rely on your memory. There would be dozens of decisions made by a minister in the portfolio every week that don't involve allocating this funding in this way, which minister is making those decisions?

Ms Beauchamp: I think the general thing—not rule or protocol—is where there's a change in policy, it's decided through cabinet and budget.

Senator McKenzie: On a day-to-day level, though, it's Minister Wyatt.

Senator WATT: Can you give me some examples of decisions that Minister Wyatt has made in the portfolio over the last month?

Ms Beauchamp: He's probably made a number of decisions with his delegation around proposals relating to some aged-care providers and Indigenous health providers.

Senator WATT: On the other hand, can you give me some examples of decisions in the Ageing portfolio that Minister Hunt has made over the last month?

Ms Beauchamp: I can't off the top of my head.

Senator WATT: Does Dr Studdert know?

Dr Studdert: As you've noted, Minister Wyatt is the Minister for Aged Care and makes the daily decisions around a whole range of matters. Just last week he introduced legislation into the House around quality standards. I think Minister Hunt and all the ministers in the portfolio are involved in budget decisions as part of the process that Ms Beauchamp has described.

Senator WATT: So budget decisions are made by this ministerial task force?

Dr Studdert: In the case of the ageing task force, yes, and the whole ageing package.

Senator WATT: That is headed by Minister Hunt?

Ms Beauchamp: Budget decisions and priorities and policy changes are made by cabinet.

Senator WATT: But the task force you talked about—which minister heads that?

Ms Beauchamp: That was a task force that was headed by the Treasurer, and it was the Expenditure Review Committee in cabinet that made the decisions.

Senator WATT: Does Minister Hunt receive copies of Minister Wyatt's briefings?

Dr Studdert: Not as a matter of course. If it is something that we would expect might be of interest to him, we would do that, but not as a matter of course, no.

Senator WATT: So significant matters are shared with Minister Hunt?

Dr Studdert: As we do with all the ministers in the portfolio.

CHAIR: Senator Smith has a few questions in this area, I believe.

Senator DEAN SMITH: Secretary, using budget moneys to give Australians greater choice about the type of care they might receive, whether it be in residential aged care or community aged care, is not a new budget initiative, is it?

Ms Beauchamp: I think when you're looking at the research that we have before us—

Senator DEAN SMITH: No, no. More specific than that: if you go to the 2010-11 budget paper, you will see, under Health and Ageing, a statement there at page 22:

The Government—

A Labor government, if I'm not mistaken—

will redirect funding of $247.7 million over four years from high-level residential aged care to high-level community aged care to ensure new high-level community aged care places …

It then goes on to say:

This measure will provide savings of $9.0 million … due to the lower costs associated with delivering care at home …

While increasing greater choice et cetera. Then again, in the 2011-12 budget paper, under the Health and Ageing initiatives, it says:

The Government—

Again, the previous Labor government—

will ensure additional high-level community aged care places are made available by temporarily adjusting the balance between high-level community aged care and high-level residential aged care.

Then—more alarming for people like Senator Watt—in 2012-13 the budget paper, when it talks about the Living Longer, Living Better initiative, says:

The Government will provide $955.4 million over five years …

And, importantly:

… of this amount, $454.0 million … has been re-directed from funding previously allocated to residential care.

In your previous evidence, Secretary, when you said that previously savings might have been directed to consolidated revenue, did you mean away from aged-care services, and would that have been an example of a shift to consolidated revenue?

Ms Beauchamp: Without having that detail—

Senator DEAN SMITH: I'm happy to table them.

Ms Beauchamp: that is correct, yes.

Senator DEAN SMITH: Thank you.

CHAIR: Given it's almost 11 o'clock, we will suspend for 15 minutes.

Proceedings suspended from 10:59 to 11:15

CHAIR: We will resume with the examination of the Health portfolio, cross-portfolio and corporate matters.

Senator WATT: I've got some general questions about the process of preparing for estimates. Ms Beauchamp, who comes up with the briefs that are included in your folder? Is that a departmental exercise or is it the minister's office, or a combination?

Ms Beauchamp: It varies for me as an individual. I grab bits and pieces from all over the place, whether they're question time briefs, media releases or a combination. Normally, in the department, we just go through what the issues of the day might be.

CHAIR: You bring the dusty folder down from the shelf!

Senator WATT: Do you set out a range of topics that you want to have briefs on or do people provide them to you unsolicited? How does it work?

Ms Beauchamp: Both ways.

Senator WATT: So some you ask for and others are provided to you by people in the department or the minister's office?

Ms Beauchamp: People in the department. We take this across the department and look at preparing within the department.

Senator WATT: What input does the minister's office have in suggesting topics that you should have briefs on; that kind of thing?

Ms Beauchamp: None to us. We do it in the department, given that we appear before Senate estimates three times a year.

Senator WATT: Are any of the briefs that you have drafted by ministerial staff?

Ms Beauchamp: No.

Senator WATT: It's all done by departmental staff?

Ms Beauchamp: Yes.

Senator WATT: Do you meet with the minister or his office prior to estimates to talk about topics that might come up and how to respond; those kinds of things?

Ms Beauchamp: We meet, for example, with Minister McKenzie to go through an outline of all the programs and subprograms that might be discussed.

Senator WATT: That's in the weeks leading up to estimates?

Ms Beauchamp: Days.

Senator WATT: Days leading up to estimates; okay.

Senator McKenzie: Not weeks!

Senator WATT: What coordination happens with either Minister Hunt or Minister McKenzie and their offices on the day of estimates itself?

Ms Beauchamp: What do you mean by 'coordination'?

Senator WATT: Do you catch up again beforehand, just to prepare for topics that might come up and how questions could be answered, on the day of estimates?

Ms Beauchamp: In my role, I'm talking to ministers on a regular basis. We talk about things that might be in the media or, for example, things that you give us a heads-up that you are going to raise.

Senator WATT: I meant to check that you've got people lined up for that.

Ms Beauchamp: We'd make sure that that information was known across the portfolio.

Senator McKenzie: I meet with my staff before estimates. We had a chat this morning about what we thought was going to happen.

Senator WATT: And do you or Minister Hunt or their staff meet with Ms Beauchamp on the morning of estimates as well, just to talk about possible questions and how they should be dealt with on the day of estimates?

Senator McKenzie: I think we caught up this morning.

Ms Beauchamp: Yes, we caught up this morning and just went through: have we got the folder; have we got all of the information we need; what are the likely questions to be raised; what's running in the media, for example; and being clear about, given it's a two-day estimates, what's going to be raised in day 1 and day 2.

Senator WATT: Does any of Minister Hunt's staff or Minister McKenzie's staff ever send you emails through the hearing with suggested answers to questions?

Ms Beauchamp: Not suggested answers to questions, no.

Senator WATT: Or clarifications or other information? Is anything emailed to you from ministerial staff?

Ms Beauchamp: No, I get advice SMSs from my staff occasionally.

Senator WATT: From departmental staff?

Ms Beauchamp: Yes.

Senator WATT: And do you get any SMSs from ministerial staff?

Ms Beauchamp: No.

Senator WATT: During estimates?

Ms Beauchamp: Not normally, no. Not generally, no.

Senator WATT: And no other platforms—Wickr, WhatsApp or any of those sorts of things?

Ms Beauchamp: I haven't got my iPad open. No, I don't.

Senator WATT: So there's no means by which ministerial staff provide you with suggestions about how to respond to questions or anything like that?

Ms Beauchamp: No, I'm trying to do this to the best of my abilities.

Senator WATT: No problem. I think that's it for us for cross portfolio.

Senator DI NATALE: I have a few more questions around the issue of out-of-pocket cost. Professor Murphy, are the terms of reference for the advisory council publicly available?

Prof. Murphy: Yes, in the media release it listed the names of the members. I'd have to take it on notice whether we actually published the terms of reference, but there's no reason why—we'd be very happy to provide them. They're not a secret document at all.

Senator DI NATALE: Can I ask you to perhaps take the terms of reference on notice?

Prof. Murphy: Yes.

Senator DI NATALE: Great. You're happy to table that.

Prof. Murphy: Yes.

Senator DI NATALE: With the composition of the council, who's on it?

Prof. Murphy: There is a representative of the Consumers Health Forum, a representative of Private Hospitals Association, a representative of Catholic Health Australia, a representative of the health insurers and a number of medical leaders: the president of the College of Surgeons; a representative of the AMA Federal Council, the president of the College of Obstetricians and Gynaecologists, the president of the College of Anaesthetists, the president of the College of Ophthalmologists, the head of the Neurosurgical Society and the Orthopaedic Association, and a representative of the College of Physicians.

Senator DI NATALE: Why were those specific specialities chosen?

Prof. Murphy: We wanted to keep the committee reasonably small. We wanted to feature, clearly, some of specialities where out-of-pocket costs were seen to be an issue, so that's why we chose urology, orthopaedics, surgery and obstetrics, and, obviously, the College of Physicians representative to cover the others and, obviously, the AMA is a key stakeholder. And, then, the non-medical representatives—that's pretty self-explanatory.

Senator DI NATALE: So really, the only consumer rep is from the Consumers Health Forum?

Prof. Murphy: Yes, but she has a group that advises her.

Senator DI NATALE: It's a big committee.

Prof. Murphy: Yes.

Senator DI NATALE: There's only one consumer rep.

Prof. Murphy: We had this discussion. The reality is that if you were trying to establish whether there was a problem or not, you would have a lot of consumers. We came into this committee with the clear position that there was a problem and it needed solving, and that the solution needed broad buy-in from medical leaders. That's why—

Senator DI NATALE: But doesn't it have to satisfy the needs of consumers first and foremost? It's not the needs of doctors.

Prof. Murphy: It exactly does.

Senator DI NATALE: And, of course, we go back to that concern that if you're going to put the onus back on consumers to be more literate, to have more information and to shop around, whether those solutions are workable should be up to consumers, not up to doctors.

Prof. Murphy: That is a key purpose of the committee, and that's why the consumer representative has convened a group of consumers to reality test every product we come up with. They feel that it's perfectly fine for them to test what we come up with in their own group, and she can report back on that basis, and she feels perfectly adequate in terms of representation of consumers. She engages broadly with the information that we give her.

Senator DI NATALE: I think there have been a number of requests for a Productivity Commission review. Does the committee have a view on that?

Prof. Murphy: The committee hasn't discussed that issue, no. The committee has focused entirely on developing a transparency solution and getting rid of hidden fees and booking fees. That's pretty much what its purpose is.

Senator DI NATALE: So, I'll wait for the terms of reference to be distributed.

Ms Beauchamp: And just to confirm, the terms of reference are on the website.

Senator DI NATALE: Great. That's easy. I can go and check that out.

Ms Beauchamp: But we do have a copy here, if you want one tabled as well.

Senator DI NATALE: Thank you. I just want to go back to that issue—and I think we traversed it when we were talking about radiotherapy—I absolutely accept that it's patient choices here; we've got a mixed system, and there is a significant number of private operators, private hospitals, private providers and so on. But isn't the most effective way, as a consumer, to be sure that you're not going to be faced with out-of-pocket costs to have an effective, well-funded public health system?

Prof. Murphy: As I said, we're working on the premise that the community has expressed a view for a mixed private-public health system. It's not my role to make a policy opinion on what sort of system we should have. We're working on the basis that we have a hybrid system.

Senator DI NATALE: But, with respect, the community hasn't expressed a view. The community's been forced into a view because they're penalised if they don't take out private health insurance if they earn over a particular amount, and there are incentives for them to take out private health insurance. So, it's not a value-free choice. This is a choice that is being influenced by the incentives and disincentives within the system.

Prof. Murphy: I don't think that's something I should comment on.

Senator DI NATALE: Okay. I will leave it there. I have a few other questions, but I can deal with those through private health. Thank you.

Mr Wann: If I could make another correction: I might have mentioned a number of 200 priorities, or thereabouts. My staff have got back to me via text and have amended that. It's actually 63 administered priorities—

Senator SINGH: Wow—that's a big difference!

Mr Wann: covering 1,008 cost centres. In bill 1 there are 44 priorities and 832 cost centres. In bill 2 there are two priorities and 39 cost centres. In the special accounts there are two priorities and 45 cost centres. In the special appropriations there are 15 priorities and 92 cost centres. But we will come up with a full list. I apologise for that.

Senator SINGH: So, where did you get the figure of 200 from?

Mr Wann: It was a voice from the back. Next time I'll make sure. Sorry about that.

Senator SINGH: It's quite a difference. Well, at least there's less for you to take on notice now.

Mr Wann: Well, yes.

Ms Beauchamp: It's still a lot.

Mr Wann: It is still a lot. And it is mostly in bill 1, so I was kind of right about that.

Senator GRIFF: I have a very brief question—just some clarification, really. Cannabis oil has been approved for prescription for patients with conditions such as severe unresponsive seizures. I've heard from a constituent whose son, who relies on the disability support pension, is paying $612.50 plus $100 postage for a 25-millilitre bottle for his seizures, and he

goes through four millilitres a day. Is there a measure whereby cannabis oil is or could be publicly subsidised?

Ms Beauchamp: Chair, this is not cross-portfolio.

Senator GRIFF: The question actually is, 'Where does it fit?'

Ms Beauchamp: But we have got—

Senator McKenzie: It's 5.1.

CHAIR: Insofar as Professor Skerritt can answer the question quickly, if it needs to be answered in 5.1, then—

Senator GRIFF: I don't want any more detail apart from the fact of where it would actually sit.

Prof. Skerritt: The Commonwealth government only subsidises medicines following a recommendation from the Pharmaceutical Benefits Advisory Committee to the minister, and those medicines have to be registered by TGA. There is one can cannabis product registered by TGA. There are a number that are currently unregistered products, some of which are going through clinical trials leading towards registration. Some states and territories, such as Tasmania and Victoria, have schemes where they do provide some compassionate access and provision of the costs. What I would suggest your constituent do is essentially shop around. There is a range of cannabis products that have been brought into the country and, because of that competition, their prices have dropped. The first three crops of commercial cannabis have also been harvested in Australia and, while it will be a little time before they're converted into products, we expect local cultivation will also result in a decrease in the price of those products.

Senator GRIFF: Thank you.

CHAIR: We will move on from cross-portfolio. We shall go to outcome 1: 'Health System Policy, Design and Innovation'; program 1.1. Senator Singh, we're going to start there.

Senator SINGH: I want to ask some questions relating to the Medical Research Future Fund. When the government announced the MRFF in the 2014 budget, it said the MRFF would disperse $1 billion a year by 2022-23. Is that still the government's commitment?

Ms Edwards: Can I check the question, please, Senator, in terms of the disbursements from the MRFF? You're after an answer about how much has been dispersed?

Senator SINGH: Yes, as it said in the 2014 budget. It said that $1 billion would be dispersed each year by 2022-23. I'm just checking that's still the case.

Ms Kneipp: Every year in the PBS statements for both Health and Finance, the profile is expanded to another year. The recent forward estimates for the MRFF are published on page 47 of the Health PBS. It effectively takes us out to the year 2021-22, with close to $2 billion available in MRFF disbursements.

Senator SINGH: So there's $2 billion to disperse in this current financial year. Is that what you're saying?

Ms Kneipp: No—correction, Senator: it's over the forward estimates, from the year 2016-17 to 2021-22.

Senator SINGH: So there's $2 billion to disperse each year in the forward estimates?

Dr Hartland: That's accumulative over that period, from 2016-17 to 2021-22.

Senator SINGH: That level of disbursement depends on a $20 billion capital fund. In the 2018 Budget Paper No. 1, statement 7—I'll take you to page 7-18—it says the MRFF 'is expected to reach a balance of $20 billion in 2020-21'. Is that your understanding as well?

Ms Kneipp: That is our understanding based on modelling provided by the Department of Finance. As you know, the Department of Finance is the owner of the legislation for the MRFF Act 2015, as well as managing the fund.

Dr Hartland: Senator, these aspects of the balance of funds are within the Department of Finance portfolio. Their portfolio budget statement provides details of the credits and balance in the fund.

Ms Kneipp: For reference, that's on page 32 of the Finance statement.

Senator SINGH: In relation to page 47, you referred to the $2 billion accumulative figure. Is it correct that the government is committed to $1 billion a year from 2022-23, after the forwards? Is that still the commitment? That is what was in the 2014 budget announcement.

Ms Edwards: We can provide you with information about the disbursements available up until 2021-22, and the amounts that have been invested to date over that period. We haven't got any figures in relation to what's happening after that event. Issues to do with the performance of the fund and so on are matters for the Department of Finance.

Ms Beauchamp: But that's certainly the target, Senator. When you look at the forward estimates in terms of disbursements—in 2020-21 we're well on the way there, with $642 million identified in the Finance portfolio budget statements as disbursements from the MRFF.

Senator SINGH: I was just asking about 2022-23 and if it's still a commitment of $1 billion a year from that date.

Ms Beauchamp: That's still the target, and it's outside the forward estimates.

Senator WATT: But it's only a target. There's obviously a difference between a target and a commitment.

Ms Edwards: Matters in relation to disbursements—what's available over the fund—really should be directed to the Department of Finance. We're certainly aiming towards having disbursements up towards $1 billion a year, but we can't comment on the detail of them.

Senator SINGH: If I take you back to Budget Paper No. 1 statement 7, it also shows that the balance of the MRFF is $7.1 billion as of 31 March 2018. How will it reach $20 billion, which is obviously another $13 billion in just two years?

Ms Kneipp: Again, Senator, we direct you to the Finance portfolio statement, which shows the modelling in terms of credits to be deposited into the endowment fund to allow it to reach that $20 billion target.

Senator SINGH: I understand that the government's previously pushed the $20 billion target back—I think back one year, from 2019-20 to 2020-21. Will you still have to push it back again?

Dr Hartland: This is a matter for the Department of Finance.

Senator WATT: But it's in your budget papers, isn't it?

Dr Hartland: No. The credits and balance of the funds are in the Department of Finance budget papers.

Senator SINGH: Well, you must be able to tell the committee where the $13 billion is coming from.

Dr Hartland: No, Senator. This is a matter that you'll have to ask the Department of Finance about. They run this aspect of the MRFF.

Senator SINGH: It's under the government's contributions to the MRFF in PBS No. 1. Did this department have nothing to do with that?

Dr Hartland: We don't manage the credits or the balance of the fund. The Department of Finance manages the credits into the funds and the balance of it.

Senator WATT: Are you concerned that it won't reach $20 billion as was initially predicted?

Dr Hartland: I think that's a softer form of the previous question, Senator.

Senator WATT: Yes, but I'm asking you from the Health Department's perspective. It's your responsibility to allocate these funds. Are you concerned that the $20 billion won't be there?

Dr Hartland: The Department of Finance's budget statements show an accumulation of the fund that gets to $20 billion by 2020-21. We would rely on that statement.

Senator SINGH: Well, all of the government's contributions to the MRFF so far have come from cuts elsewhere in the Health portfolio. Does the portfolio expect to contribute all of the remaining $13 billion that's needed to reach this $20 billion?

Ms Beauchamp: Senator, can I clarify the previous statement about disbursements coming from cuts to the portfolio? I'm not sure where you got that information from.

Senator SINGH: Are you saying that that's not the case?

Ms Beauchamp: That's not the case. The disbursements come from the fund, not from elsewhere in the—

Senator WATT: We're not talking about the disbursements from the fund; we're talking about contributions to build up the fund.

Ms Beauchamp: As Dr Hartland said, I think the Medical Research Future Fund Act 2015 is administered by the Department of Finance, and it's up to the Department of Finance to source the contributions from the Commonwealth government across government.

Senator SINGH: But the contributions for this fund have come from the Health portfolio. We are asking the Department of Health, because this is the Health portfolio, about those cuts to the Health portfolio in creating the fund—

Dr Hartland: The fund's created by realised savings from the Health portfolio. The Department of Finance makes that calculation.

Senator SINGH: Yes, realised savings of the Health portfolio. My question is specifically about whether or not the Health department expects to contribute to some or all of the remaining $13 billion to make up this fund.

Dr Hartland: These would be previous savings measures announced and dealt with by either parliament or administrative action, and the Department of Finance's role is to calculate what effect those savings have had and what proportion goes to the MRFF fund.

CHAIR: Senator Singh, you're asking for the official's opinion on future government policy.

Senator SINGH: No, I'm not asking for opinion.

CHAIR: I think you are, actually.

Senator SINGH: No, I'm asking whether savings are going to come from this portfolio to contribute to the health fund.

CHAIR: It's a hypothetical.

Dr Hartland: A savings measure will have effect over time. The Department of Finance calculates what that effect is and what proportion of that can be provided to the fund.

Senator WATT: Have you had any discussions with the Department of Finance about future cuts, reallocations, transfers or whatever term you want to use that may be made within the Health portfolio to fund contributions to this research fund?

Ms Edwards: No, we haven't.

Senator WATT: There have been no discussions?

Ms Edwards: No, there are existing measures in previous budgets that set up and contributed to the MRFF. It's now managed by the Department of Finance. We have had no discussions and are not aware of any proposals for future measures affecting the Health portfolio to factor into the MRFF.

Senator SINGH: Is the department aware of where money in the Department of Health will come from to contribute to the MRFF?

Ms Edwards: The MRFF was set up under previous budget measures, and those are continuing and being managed by the Department of Finance.

Senator SINGH: Can you rule out further cuts to Health as the government tries to get this $20 billion in capital fund?

Senator McKenzie: 'Further cuts to Health,' Senator Singh?

Senator WATT: In addition to the ones you've made.

Senator SINGH: Yes, because there have been cuts to Health to contribute to the Health portfolio.

Senator McKenzie: I think we've been really, really clear this morning that there are no cuts to the Health portfolio.

Senator WATT: The officials just said that this research fund is being funded by cuts, transfers, reallocations—pick the synonym you want other than 'cuts'.

Senator McKenzie: I thought 'redistribution' might be one that you like, Senator Watt.

Senator WATT: Okay, redistributions. But this research fund has been funded from redistributions within the portfolio. That's the cut we're talking about.

Senator McKenzie: Which are not cuts. Nothing's going back to consolidated revenue.

Senator WATT: What is a cut?

Senator McKenzie: Under your previous government, they would.

Senator WATT: How do you define a cut?

Senator McKenzie: They are defined as cuts, the cuts that your former government made in the Health portfolio.

Senator WATT: Not for this fund. It's all yours.

Ms Edwards: To be clear, we're not aware of any proposed measure, nor should we be, and there is no existing measure other than those set out in previous budget papers of contributions to the MRFF. It's not something we've had any discussions with Finance or anyone else about.

Senator SINGH: The Finance portfolio budget statement shows the total available from the MRFF in each year. Can you tell me how much of this has already been committed to particular disbursements?

Ms Edwards: Yes. Of the just over $2 billion available in disbursements since the establishment of the MRFF, there's been $1.77 billion committed or announced for investment out of the MRFF.

Senator SINGH: What year was that?

Ms Edwards: Over the duration of the fund.

Senator SINGH: Let's go through it. In 2018-19, $214.9 million is available. How much of that has been—

Ms Edwards: We might start in 2016-17, which was the first year of disbursements being committed, which was $18 million. In 2017-18, $143.4 million. In 2018-19, $236.2 million. In 2019-20, $332.1 million. In 2020-21, $369.6 million. In 2021-22, $233.6 million. There have also been commitments in relation to out years of $437.5 million, taking us to the total of $1,770.4 million.

Senator SINGH: Okay. The budget papers appear to include around $1.6 billion in further MRFF disbursements across two measures. Is that right, or are some of the disbursements counted in both measures?

Dr Hartland: We can take you through the government's recent announcements in the budget on MRFF funding.

Senator SINGH: What I'm after is a breakdown of spending by disbursement. and year over the next 10 years. I'm happy for you to take that on notice because we might be here a while.

Ms Kneipp: That's all on the public record, and the budget fact sheets are as well. A major component of that was the National Health and Medical Industry Growth Plan, which effectively is about $1.3 billion, and then there are a further $500 million of commitments for other MRFF-related projects. The minister has chosen to articulate those programs around four themes—patients, researchers, missions and translation. If you would like an easily captured table that summarises all the programs and their forward estimates, we can put that together for you.

Senator SINGH: That would be good. Is it correct that some of the disbursements are counted in both measures? That was the previous question I asked about the $1.6 billion in further MRFF disbursements?

Dr Hartland: The fact sheets and the measures that the government announced all contain a number of programs, but there's no double counting.

Senator SINGH: As I recall, the process for MRFF disbursements is roughly that the Australian Medical Research Advisory Board develops a five-year strategy, currently for 2016 to 2021.

Ms Kneipp: Yes.

Senator SINGH: The board develops two-yearly priorities, currently for 2016 and 2018. The board makes recommendations to the minister in disbursements that fit within the strategy and priorities, and then the minister makes disbursements. Is that correct?

Ms Kneipp: Effectively. The act requires this board to conduct a national consultation with the sector and the community about how to articulate those priorities, and the government makes the decisions. The board does not influence government decision-making about how the disbursements are made. In fact, as you got those years right, the current set of priorities—the inaugural priorities—are 2016-18. In July and August of this year, the board will start another national consultation to develop the second set of priorities for the MRFF.

Senator SINGH: Were all the disbursements in this budget recommended by the board?

Ms Kneipp: Again, the board doesn't recommend how to make the disbursements. It sets priorities, and the government takes those priorities into consideration as the board's advice when deciding how to make the disbursements and associated commitments.

Senator SINGH: How did these disbursements come out about, then? On what basis did the minister make disbursements?

Ms Kneipp: The minister has some conversations with the board, but, at the end of the day, program design is something that is done in consultation with the department and the minister's office.

Senator SINGH: Not the board recommending—

Dr Hartland: The board doesn't recommend specific programs.

Ms Kneipp: They advise.

Senator SINGH: Is that the case for all the previous disbursements as well?

Ms Kneipp: Correct, yes.

Senator SINGH: So the board advises?

Ms Kneipp: Yes, and the chair of the board, Professor Ian Frazer, is very clear publicly that his role is not to decide where the money goes but to advise on how to best use the money in program design.

Senator SINGH: And then the minister decides?

Ms Kneipp: Yes. Ultimately, it's a decision for government.

Senator SINGH: Can you explain the $20 million for the Australian Medical Research Advisory Board itself?

Ms Kneipp: Those funds are not actually taken out of the MRFF because the MRFF Act only requires that funds are used to fund research directly. But the advisory board is taking on a much greater role in oversighting not the implementation but the direction of the MRFF. With the industry growth plan now in place, as well as the significant investments in missions—in particular, the Genomics Health Futures Mission—the government's made the decision that the advisory board can play more of a governance and oversight role to some of these investments to ensure the return on value.

Senator SINGH: It says, in that part of the budget, that the $20 million is to support the Australian Medical Research Advisory Board to develop strategies and priorities for health and medical research and innovation. That seems a lot.

Dr Hartland: The MRFF is a slightly different program to some other research funding programs. There's a high expectation about public consultation and consultation with expert groups for the board. There's also considerable expectation around actively managing the program and the grants so that they produce pay-offs in terms of clinical discoveries and techniques and benefits to the industry. In essence, the government felt that more resources need to be put into those aspects of managing it to make sure that the program's successful.

Senator SINGH: So you're saying developing strategies and priorities includes consultation?

Ms Edwards: Yes, it can.

Dr Hartland: Yes, that's right.

Ms Beauchamp: That $20 million is a 5-year figure. It's not a normal forward estimates figure. One of the big initiatives announced in the budget was $1.3 billion for the Health and Medical Industry Growth Plan, which was in the Treasurer's statements. That has about five key elements. I think the money that you're speaking about is making sure that the advisory board takes a more active role in implementation of each of those measures under the growth plan. Some of the money does extend beyond the five years as well. One of the things I think government wanted to be assured about was implementation of the Genomics Health Futures Mission, the Frontier Health and Medical Research Program, five years, the rare cancers and rare diseases trials, the Targeted Translation Research Accelerator, and $94 million over the four years for industry research collaboration. So there's a big task in that delivery of the industry growth plan. $20 million has been set aside to help the board and make sure the board can oversight and monitor developments around that industry growth plan.

Senator SINGH: It just seems disproportionate, if you look by way of comparison. The department is only being allocated $2.8 million to administer this measure, compared to $20 million for—

Dr Hartland: The $2.8 million is a specific component. It's one aspect of one of the tasks that we need to do. It's effectively some funding to allow us to do some consultation for a second-pass business case on ICT. It's not the totality of the department's administrative effort in relation to the MRFF.

Ms Kneipp: That particular allocation is attached to the genomics mission.

Senator SINGH: This budget does make some disbursements that run for 10 years. Ten years is several MRFF strategies and priorities away and, dare I say, several governments or elections away, or both. How can the government commit to funding in 10 years when it

doesn't know what the board's strategy and priorities will be, let alone what disbursements the board will recommend at that time, all those light years away? Doesn't that contravene the process that you've just described?

Dr Hartland: No. In one aspect, it's an essential component of the MRFF, in the sense that one of the things that's different about the MRFF is that it's intended to be a more targeted and purposeful granting process than some other granting processes and to have a longer-term impact on the medical research and technology industry. As a part of that, in some areas the government's wanted to make clear its longer-term goals for investment in particular areas to give industry and researchers certainty that there'll be ongoing funding available for projects that can often take quite a bit of time. In some areas, you see some projects suffering because there's been a sense that researchers won't go into the area because they feel that there's not going to be long-term funding available to them, so their careers might suffer in the future. I think the minister has wanted to identify some areas where he's committed to a longer-term funding response to give the industry and researchers certainty that there'll be support for that area of research into the future.

Ms Kneipp: If I could add, Professor Ian Frazer talks about the MRFF being a transformational opportunity for the health and medical research sector in Australia, in which we have a very strong global reputation. Commitments through 10 years and missions with bold targets are one way of stimulating the sector and attracting talent and building jobs and growth in Australia and collaborating internationally. The board has taken a perspective in their five-year strategy to focus on priming the entire pipeline, from idea to proof-of-concept through to translation and commercialisation. One sure way to do that is to make longer-term commitments.

CHAIR: One of the criticisms of this area in the past has been that research has been constantly chasing the next round of funding to continue studies going forward into the future.

Ms Beauchamp: The fact that this whole area is governed by an act that went through parliament was to provide that longer-term certainty, as well.

CHAIR: I have some questions on this area. Is there a global figure on how much the government's committed to spending on health and medical research? Is there a headline number?

Ms Beauchamp: Total portfolio research funding figure over the forward estimates, not including the longer term that we've just spoken about, is in the order of $6 billion research effort over the forwards.

CHAIR: I assume that would include the direct disbursement to the National Health and Medical Research Council?

Ms Beauchamp: It includes the disbursements through MRFF, but also the National Health and Medical Research Council annual funding as well.

CHAIR: That's what I meant—they get direct annual funding. Of the $6 billion, what percentage is that?

Ms Beauchamp: It's probably around $3.4 billion.

Ms Kneipp: On average, NHMRC is allocated around the $800 million mark. That figure that the secretary mentioned also includes the Biomedical Translation Fund. So the NHMRC, MRFF and the Biomedical Translation Fund are the key components.

CHAIR: So NHMRC is around $3½ billion, $2 billion from the MRFF, and the Biomedical Translation Fund is—

Ms Kneipp: $250 million, but remember that fund is leveraged with private capital, so it's effectively a $500 million proposal.

CHAIR: When was the Biomedical Translation Fund—what's the establishment process for that?

Ms Kneipp: It was announced in December 2015 under the National Innovation and Science Strategy. It was one of the key initiatives under that. Following a process of identifying fund managers, of which there are three, it began operation in January 2017. Basically, the fund managers go out and find the deals for advanced commercial-ready health and medical research innovations. They have to match the Commonwealth's investment with private-sector capital. So far to date, they've done nine deals at a value of about $42 million. They can invest these funds over a period of seven years.

CHAIR: Is that performing as expected, or better or worse?

Ms Kneipp: I'd say it's on track. We're pretty happy with the performance.

CHAIR: Is that something that we're expecting to ramp up over time, or is that a baseline that's just going to continue at that level?

Ms Kneipp: The idea of the BTF was to stimulate the venture capital sector and increase Australia's ability to invest in good-quality late-stage research. If I take you back to the MRFF and the MRFF strategy, a lot of the programs that are coming out in the disbursements around the MRFF are about priming that entire pipeline. We're effectively BTF priming throughout that pipeline, so that more great Australian ideas get to that commercial-ready space. It has potential to grow, but the BTF is a long-term investment, obviously. The deals can be made over seven years, and the exit strategy is 15 years.

CHAIR: The other area I wanted to ask about was the Genomics Health Futures Mission. That is a mouthful. Those who have watched estimates know I have an interest in genomics research. What is that going to do?

Ms Kneipp: The Genomics Health Futures or the genomics mission is a commitment of $500 million. The government is looking to also leverage those funds, which we're trying to do always with the MRFF. A good example is the Australian Brain Cancer Mission, where we've attracted near-matching philanthropy to that mission. Genomics is organised around six central themes. The mission will focus on the development and expansion of flagship studies focusing on rare cancers, rare diseases and complex conditions. This is where genomics is proving to have the greatest impact at the moment. Clinical trials—expanding pre-clinical and phased trials over the years. Influencing and increasing the workforce and the research capacity in this space. Commercialisation—this is where in the genomics mission we want to try and leverage some private capital, industry as well as philanthropy, to ensure that we're well positioned as a nation to harness this technology. Ethics, legal and social are significant issue, obviously. We need to bring the community along with us in the development of precision medicine, because it's destined to change the future of the healthcare experience.

And then data analytics and issues around privacy and custodianship of genome data and how that fits into the entire health system.

A couple of weeks ago the minister announced the establishment of a steering committee, again to be chaired by Ian Frazer. It's a time-limited committee of six months. Their task is basically to design the architecture of the mission and its operational mandate. It will deliver that back to the minister and through government they'll make some final deliberations about how the mission will roll out.

CHAIR: Does that structure that you just described mirror similar examples in the past, or is this a new approach?

Ms Kneipp: I guess missions are a new approach. Missions were also touched on in Innovation and Science Australia's recent strategic plan for 2030. It called for bold new missions, as you may be aware. Other nations are heading down this way. The United States has its cancer moon shot, and the UK also has a very big commitment to harnessing genomics and embedding precision medicine and healthcare. These are increasing trends that nations are taking for technologies that have great potential, and we just need to figure out how to embrace them in our system and increase access for Australians.

CHAIR: Finally on this, can you take me through the diabetes and heart research accelerator? Is that going to have a similar mission structure? How is that one going to work?

Ms Kneipp: We talk about there being along the research pipeline two problematic valleys. One valley is where a researcher or a team has a great idea but they don't have the funds or the resources to prove that idea, to bring it to a proof of concept and then start it down the pathway to trials. And the BTF is on the other side, where you've proven the idea through trials but you need commercial energy and capital to bring the concept to market. The accelerator is a program designed to fast-track initially diabetes and heart disease ideas through to proof of concept and to get those ideas into trial-setting where they can attract more private capital. It's another attempt of the MRFF trying to leverage funds by attracting industrialists and philanthropy to increase efforts in this space, because obviously those are very challenging chronic disease spaces. There is an advisory group that's been established that the MRFF advisory board is involved in trying to develop the program design.

CHAIR: Has any work been done on the level of growth of employment, new researchers, that will be needed to fulfil this investment? Do we have any idea about that?

Ms Kneipp: A key foundational program that's emerging in the MRFF is investing in clinical researchers. In fact, over the six years $76 million has been made available under the MRFF. The fund is actually working with the National Health and Medical Research Council to ensure there are more fellowships out there to attract more Australians into the research space. We hope, as we invest in these various programs, that more people will decide to choose a life of research, or become a clinical researcher, because, essentially, these ideas will eventually become the jobs of the future and the new businesses that are created. It's all about supporting STEM.

CHAIR: Obviously, if you're going to invest this money then you need to have a pipeline of people coming through who can actually perform the research. Have we quantified that in any way?

Ms Edwards: In relation to the National Health and Medical Industry Growth Plan, which is an element of the MRFF, we've done some work and had some people help us do some calculations, and it's estimated to inject $18 billion into the Australian economy and cement our place as a world leader in this industry. It's also been estimated that there will be 28,000 new jobs, for a minimum of 130 new clinical trials, and a 50 per cent increase in exports, new markets and global market leadership in biotechnology, medical devices and pharmaceuticals.

CHAIR: Great. So we actually have considered how we're going to boost the workforce to supply the research that we need to improve our health system into the future?

Ms Edwards: The approach to research will be both fundamental in saving lives and helping individual Australians but also an important part of putting us at the forefront of what is a really modern, high-tech industry.

CHAIR: Excellent. Thank you.

Senator DI NATALE: Following on from Senator Singh's questions, has the department received any feedback from the research community that the process for disbursement is unclear? That's the message we're getting repeatedly from the medical research community—that they just don't have clarity about how the fund's going to be allocating its money.

Ms Kneipp: Just the other week, the Australian Medical Research Advisory Board met with peak bodies from the health and medical research sector and others, and this was a focus of the conversation—the need to ramp up our communication strategy around the MRFF. It was a very productive conversation. You may have noticed that we've actually launched a new website in the beta format, which we're using as a platform for improving that communication. In fact, we're hoping to move towards having a little working group that supports the advisory board to flag where there are gaps in knowledge and how we can quickly get those messages out.

Senator DI NATALE: I don't think their issue is one of communication; it's actually one of clarity of knowing how these issues are being made—what the basis of the allocation of funds is. I understand it's a ministerial decision ultimately, but there doesn't appear to be any clear framework that ensures the medical research community knows how the money is allocated and therefore how they themselves can decide to structure the work that they do. What work is being done, not on communicating, but on clarity around the framework?

Dr Hartland: I think the government's announcements, many of which go beyond the forward estimates period, provide a clarity around the framework that the government is using to make disbursements.

Senator DI NATALE: What does that mean?

Dr Hartland: It means that the government's announced the framework that it's using for disbursements in the budget.

Senator DI NATALE: Talk me through that.

Dr Hartland: The government's announced, for example, a commitment to a Genomics Health Futures Mission—

Senator DI NATALE: So, do we take that as: this is now going to be a central focus of the disbursements of funds for the fund, or are we looking at that as a standalone allocation of funding? The point is: we're hearing this from the researchers. It's not that we're asking you on

behalf of ourselves in this space; it's actually the research community who are saying this to us repeatedly. I can't tell you how many functions I go to where they say: 'We just don't know how the money's being allocated. We don't know what the basis is. We don't understand the framework. We see these announcements. They sometimes appear to be disconnected. They're sporadic. We just don't have clarity.'

Ms Kneipp: Yes.

Senator DI NATALE: Are you hearing the same feedback?

Ms Kneipp: Yes, and we are working on that; I can assure you of that. The first disbursements from the MRFF made in 2016-17 were for one year only. The next lot of disbursements that have come in and around the budget just passed are four to five years in duration. So, what you see emerging are foundational programs, and, for the sector itself, a sense of routine. If you look at clinical trials, an additional $248 million over the next five years has been announced, which means every year there will be a round for clinical trials. The fellowships commitment goes over the next five years. Every year there will be opportunities through the NHMRC to hold an MRFF fellowship. It's creating a sense of routine which we didn't have with the first disbursements but we are trying to program into the future. The other thing, too, is we need to take the decisions that the government makes around disbursements, translate them into programs—design the program—and then communicate the opportunities to the market.

Senator DI NATALE: So it's fair to say, then, that the government's announcements around disbursement drive the priorities, or the programs?

Ms Kneipp: The programs.

Senator DI NATALE: The programs that sit underneath that?

Ms Kneipp: Correct.

Senator DI NATALE: So, ultimately, the minister can, at a whim, decide to put a hundred million bucks into project X, and then you retrofit that with the programs—

Ms Kneipp: It has to be consistent with the priorities that the advisory board has set.

Ms Edwards: It's important to note that all the programs to date are entirely consistent with the independent medical research and innovation priorities that were developed. There is a real consistency there. People can go and look at those priorities.

Senator DI NATALE: They're pretty broad. There's a lot of discretion for the minister to decide what to fund in what areas.

Dr Hartland: What to fund is a different question. All of the programs have a separate process around selecting individual grant recipients.

Senator DI NATALE: But the dollars are what determine the priorities ultimately. You can have a broad set of priorities, but if you put a hell of a lot of money into one area that becomes the priority, doesn't it?

Dr Hartland: Yes, that's right.

Senator DI NATALE: And, ultimately, that's a decision for the minister?

Dr Hartland: For the minister—well, the minister needs to go to cabinet.

Senator DI NATALE: For the government of the day?

Dr Hartland: That's right, yes.

Senator DI NATALE: Again, we should be trying to create an evidence based framework where investment dollars are being allocated according to need, not according to, as I say, the minister of the day's—some people will call them priorities; other people might call them pet projects, and other people might call them election opportunities, depending on what perspective you're coming from. But shouldn't it be coming from the bottom up in the way that the NHMRC does their work?

Ms Kneipp: NHMRC can speak for itself, but historically there's been a lot of investigator-driven research. Correct?

Senator DI NATALE: Yes.

Ms Kneipp: MRFF is priority setting research. The act requires the board to consult with the community and the sector about the priorities, which makes the priorities a document that the community owns, that the government considers when making decisions. The issue that I think you're trying to articulate just emphasises the importance of the sector and the community getting engaged in the board's consultation process, which is a message we've been spruiking a lot.

Senator DI NATALE: I think that's important, but I suppose the concern I've got is how that actually translates to where the money flows and how that reflects all of the priorities that are agreed upon. Ultimately, again, it becomes a question for government, the minister of the day, to decide where to allocate the bulk of that funding.

Ms Beauchamp: It might be worthwhile us putting together how all of the different elements fit together with the MRFF, the NHMRC and the BTF. I think it's a combination of investigator-driven processes, but also the government identifying where the gaps are, particularly translation research. The MRFF has been used a lot for the translation research and identifying those gaps. It's probably more than just communication—I agree—and perhaps we need to look at how we map and how we engage researchers, because a minister doesn't make these decisions alone; he actually does consult with key stakeholders and particularly the advisory board. So, we might put something together that shows how all these bits fit together.

Senator DI NATALE: We're into the third year now?

Ms Kneipp: The second year of disbursements.

Senator DI NATALE: The second year of disbursements and the third year of the fund. This is the second year that money has flowed—but the fund was established before that—and we're still having this feedback from the research community: 'We actually don't know how the decisions are being made.' That's a problem.

Ms Beauchamp: If that's coming from some elements then—

Senator DI NATALE: I think it's already been acknowledged by the department that that's an issue.

Ms Beauchamp: perhaps it's up to us to articulate better how the various elements of government's research effort fit together.

Ms Edwards: We also note that many of the researchers that we deal with are very excited and enthused by this particularly huge investment. The fact that the government has

made such a long-term clear commitment in genomics, for example, in mental health and so on, really gives guidance on where that money is going to be available long-term for researchers to do key priorities. There is obviously more work for us to do in terms of how we administer the project. But it is something that I think has really excited and enthused a lot of researchers, and we are aiming to consolidate on that as we roll out the programs.

Senator DI NATALE: How much of the funding has gone towards prevention or chronic disease?

Ms Kneipp: In the first disbursements, $10 million went towards The Australian Prevention Partnership Centre, or TAPPC.

Senator DI NATALE: And what proportion of the total disbursement is that?

Ms Kneipp: That was $10 million out of $60 million from the first year of disbursements.

Senator DI NATALE: Okay, that was from the first year. I am talking about the most recent budget round.

Ms Kneipp: It is difficult to quarantine prevention research, but there are a number of programs in this year's disbursement that would cut into that place. That obviously includes mental health research, which is often focused on prevention. Keeping Australians out of Hospital—that program is focused on prevention. Maternal Health in the First 2,000 days is definitely prevention. The Advanced Health Research and Translation Centres and the Centres for Innovation in Regional Health are very focused on rapid applied translation across the system, including primary care and hospitals. So some of their projects touch on that space as well. Then there is the accelerator that we mentioned looking at heart disease and diabetes. Obviously that might have some prevention elements.

Senator DI NATALE: When you look at what is clearly labelled as prevention—and I agree that where you draw those boundaries can be tricky—it is broadly about one per cent of total disbursements. I am wondering how that fits in with the priorities that have been established.

Ms Kneipp: Prevention is identified in the priorities. We can take that on notice. You can create the program and go to market and call for it. It is the researchers' ideas around solutions to the problem that will show you where on that care continuum there effort is going to lie.

Senator DI NATALE: Given that it is a priority, if it is only one per cent you would hope to be increasing the proportion of funding for prevention activities over time.

Ms Kneipp: Yes.

Ms Edwards: I don't think our calculation would have it as one per cent. We might have to come back to you another time.

Senator DI NATALE: On notice—that would be great.

Ms Kneipp: With caveats.

Senator DI NATALE: That's fine. I'm talking about clearly prevention labelled activities, but you may have a different—

Ms Edwards: It is certainly a much higher percentage when you consider the things being worked through with some of the major projects.

Senator DI NATALE: Maybe you could provide that on notice. That would be great.

CHAIR: I think we have a couple of senators with questions regarding the NHMRC. Senator Steele-John, do you want to kick off?

Senator STEELE-JOHN: Yes. I would like to ask some questions on behalf of the between 94,000 and 240,000 Australians who journey with ME/CFS. I would like to specifically ask questions around the advisory committee which exists within the NHMRC in relation to this issue. First of all, how did you select the scientific and research members of the advisory panel?

Prof. Kelso: Thank you for the question. As you would probably know, we have been interested for several years in developing some kind of response to the very difficult issue of ME/CFS. We have formed an expert committee which is made up of people with a particular interest in this sort of issue and with the type of clinical and biomedical skills that are necessary to understand the type of clinical situation, as well as representatives of patient organisations with a particular interest in ME/CFS.

Senator STEELE-JOHN: Fantastic. Take me through the selection process. Was there a call-out? How did you go about soliciting the members of this committee and then sifting through to select the ones that you wanted?

Prof. Kelso: As is usually the case with committees like this, we seek advice on appropriate expertise. Rather than calling for nominations, we seek advice and form a committee which attempts to balance a broad range of expertise and types of research as well as the consumer understanding and involvement.

Senator STEELE-JOHN: Do you have a formula which gives a certain weighting to expertise over consumer experience, say?

Prof. Kelso: No, it's not a particular weighting. It would be normal for us to have at least one consumer representative. We have three on this committee, which reflects the fact that there are two different groups. There is Emerge Australia and there is ME/CFS Australia, so we have three members of the committee out of approximately 12, I think, who have direct experience with ME/CFS.

Senator STEELE-JOHN: According to the relevant section on your website, you do a lot of work to look at perceived or real conflicts of interest in the selection of committee members as well. Could I just ask you whether you would agree that it would be concerning if a member of the panel thought that ME or CFS patients could be cured by doing things like aqua aerobics?

Prof. Kelso: In considering conflicts of interest, we consider the particular expertise and whether there's any kind of financial linkage to a group which would be inappropriate. If somebody has expressed views about a particular treatment, in this case, then what would be most important is that the committee knows that those views have been expressed so that other members can take that into account in considering the input of that person. That person may have a range of skills and expertise which extend well beyond that particular point and may be valuable for the committee for that reason. The most important thing is to have everything out on the table, and then a decision is made about whether that's something that means the person should be excluded from the committee or whether their advice as a member of the committee should be moderated, if you like, by knowing that they have a particular viewpoint.

Senator STEELE-JOHN: Is it your understanding that this particular committee has been through that process?

Prof. Kelso: Yes, it is. And it's a standard process for all of our committees, of which we have many.

Senator STEELE-JOHN: You'd be aware, Professor Kelso, that there's a discourse around the psychological aspects and physical aspects of curing these kinds of things which is a particularly concerning line of questioning for many people who journey with this condition?

Prof. Kelso: I am aware that it's a controversial topic and that there are different views expressed about the contribution of different components, if you like, or different possible contributors to the symptoms. But this committee is working from the starting point that this is a real issue—it's a real clinical issue that needs to be taken seriously. Its purpose is to provide advice to NHMRC about how we can best support research or guidelines or whatever is the most useful way that we can contribute to addressing this problem in a realistic way in the community.

Senator STEELE-JOHN: Fantastic. That is wonderful to hear. I think the committee last met on 18 March. Is that correct?

Prof. Kelso: It has met recently, and I believe its next meeting is today.

Senator STEELE-JOHN: Well, that is fantastic to hear. Is it possible to provide the committee with a copy of the agenda for today's meeting, or is that published post the meeting?

Prof. Kelso: Our normal process is to update our website after each meeting. We have a particular page for this committee because we know that there's a lot of interest in the wider community. Our normal process would be to update that web page, after the committee has met, with any further progress that has been made.

Senator STEELE-JOHN: Wonderful. Are those meetings open to the public? What's the process? Can you view them anywhere, or are they held in private?

Prof. Kelso: They are closed meetings. But the intention is that the committee will draft a report later this year, and that report will be used as the basis for public consultation before they finalise their advice to me as the CEO of NHMRC.

Senator STEELE-JOHN: Is there a rough time line for the release of that report?

Prof. Kelso: My notes simply say that the report will be drafted later this year, and of course that depends on the committee reaching a point where they are ready to draft that report. We haven't imposed a deadline on them. We know that there have been very detailed and intensive discussions so far. That will determine whether they need to meet more times and how much work needs to be done before the draft report is released for consultation.

Senator STEELE-JOHN: Just finally, I'm wondering whether you'd be able to give an update on the NHMRC's targeted call for ME and CFS research and what discipline or field of study the proposal you are considering would explore if successful.

Prof. Kelso: At this stage, we haven't made a decision to hold a targeted call for research, because it will depend on the advice from this committee. This committee is tasked with giving us advice on the best way we can support research or other needs that are appropriate

for NHMRC to contribute for this disease. So it may not be a targeted call for research, but it's equally possible that it will be. Then we'll await their advice, if it is a targeted call, on what the scope of that call would be.

Senator STEELE-JOHN: Thank you for your time, Professor Kelso.

Prof. Kelso: Thank you.

CHAIR: I believe that is all for this outcome. Are there any other senators with questions on program 1.1 to declare?

Senator GRIFF: You've covered the majority. Perhaps, Professor Kelso, I could ask just a couple of brief questions. Do you ever actually go out and seek public expressions of interest for people who may want to be in these committees? I think you said that it's more or less worked out internally with experts that you deal with. Is there ever any time where you might go out there and say, 'We're seeking involvement on an advisory committee'? That to me would seem to be a worthwhile exercise for you to determine who else out there may be prepared to get involved who might have a high degree of expertise as well.

Prof. Kelso: We certainly do that for council and principal committees. There's a call for people to self-nominate or to nominate other people to be on the Council of NHMRC or the Research Committee or the Australian Health Ethics Committee—the several principal committees that we have. It's not normal process for the other committees which are specifically advisory to me and are not already specified in our legislation. But it is a possibility in some cases, and I'm wondering whether we have ever done it for a particular disease area. It's certainly worth us considering in cases like this.

Senator GRIFF: My understanding is that your previous committee had 14 advisory members—this was the one back in 2002—and two conveners, and the current one has six members. Is that correct?

Prof. Kelso: I'm sorry; which committee?

Senator GRIFF: The CFS committee that operated in 2002 actually had 14 advisory members.

Prof. Kelso: That's a long time before my time. I don't know if there's anybody in the team here who was around in 2002.

Senator GRIFF: You can't channel a previous—

Prof. Kelso: No.

Senator GRIFF: I can't pull it up right now, but I do have it here. This related to the guidelines that were written in 2002. There were 14 members of the committee at that time. Now, given the importance of having members with biomarker and molecular expertise—and I believe there are only a limited number of people on the current committee who have that, perhaps only one person, in my understanding—would you consider adding more members with biomarker and molecular expertise?

Prof. Kelso: We might need to take the question on notice to be certain exactly who has that sort of experience. But I can see at least one person there who I know for sure has that kind of background.

Senator GRIFF: My understanding is that there is one. But, for instance, in the US equivalent committee, all members have biomarker expertise, because, as you've indicated, it's very different now than it was, going back 10 or more years ago.

Prof. Kelso: Yes. I think that our committee composition reflects a broad view about the type of advice we might receive. Particularly there's an interest in immune biomarkers at the moment as a very fruitful area of research for a potential diagnostic for ME/CFS. That is one area where we would want to have expertise on the committee. But it's not the only area, so I think we have a broad range of clinical expertise here, including infectious disease, if I'm correct—sorry, I'm flipping through here. I think we have at least two people on the committee, one of whom is directly associated with the biomarker work at Griffith University; the other has a long-term interest in the relationship between virus infections and chronic fatigue syndromes and is a clinical immunologist and would have a very good understanding of this area. So from my knowledge, just looking quickly at the members of this committee, we have at least two who have direct expertise or the broad expertise that would be necessary to—

Senator GRIFF: And some of them would have expertise on markers for poor mitochondrial function as well?

Prof. Kelso: Mitochondrial function!

Senator GRIFF: I learnt so much when we caught up a few weeks ago!

Prof. Kelso: Yes, it's our other area of common interest at the moment. I'm not sure exactly about mitochondrial genetics expertise. That's an interesting question. I'm not aware of whether that has been identified as particularly important for ME/CFS, but I can find out about that.

Senator GRIFF: I understand that it is related to poor mitochondrial function, so I would have thought that it would have been important to have that level of expertise on the committee as well.

Prof. Kelso: Perhaps I could just add, then, that the importance of this committee is not necessarily to have a deep understanding of all of the possible mechanisms that lead to ME/CFS but to be able to give us the type of advice on what the best way we could invest in this area would be, whether it's through a targeted call for research or it's through the need for clinical guidelines. Sometimes what one then needs is a range of expertise that extends beyond the specific biology of a syndrome. So I believe we have a good mix there, but we could provide more information, Senator.

Senator GRIFF: Yes, if you could, thank you.

Prof. Kelso: Thank you.

CHAIR: Just a really quick one from me before I let you go, linking back to what department officials said earlier about the genomics mission: how does the NHMRC interact with something like that? Obviously the minister, the government, sets the priority agenda. We've got this focus. How does the NHMRC interact with that focus?

Prof. Kelso: First of all, the NHMRC has funded a lot of research in genomics over the last few years, so, in a way, NHMRC has been supporting the foundations on which this mission will be built. In particular, our two largest-ever grants have been in the area of

genomics. One was a $27.5 million grant from 2009 to 2014, which was for international projects on ovarian cancer and pancreatic cancer sequencing. Then the second one—which is really very relevant to the mission—was the targeted call for research on preparing Australia for the genomics revolution in health care. That is a national network of about 80 chief investigators led by Professor Kathryn North, who's the Director of the Murdoch Children's Research Institute. That has really established a national network, which I think by its very nature, in the work that it's doing, is the foundation on which the mission can be built. So we already have a strong interest and investment in the area.

Then it'll be up to the department and the further development of the mission, under the guidance of the advisory committee which has just been announced, to determine whether NHMRC would be directly involved in any schemes that might be rolled out under that mission. That's something that will be open to the government to use if they wish, but only if that fits in with the plan for the mission and whether it's useful to use our services, if you like.

CHAIR: I'm happy for you to take this one on notice. Does a body like the NHMRC, or another body, track, for example, the cost of gene sequencing over time? My understanding, anecdotally, is that the cost has come down massively. But does anyone actually keep an eye on that?

Prof. Kelso: I have—perhaps like you—seen many articles and heard many talks where people have shown these extraordinarily impressive graphs showing how the cost of sequencing one human genome has dropped from $3 billion—which is what the first human genome sequence cost—down to something that's approaching $1,000 today, so that it can now be considered as a support for clinical decision-making. I don't think it's difficult to find the data to support that, particularly because the starting cost of the Human Genome Project was about $3 billion. So that's basically true, I think; it's a massive drop.

CHAIR: Is NHMRC investing in any projects to try and drive down those costs even further? Is that a particular area of research? Or has that just happened in conjunction with other research efforts?

Prof. Kelso: It happened partly because the industry which produces the machines which are used for genome sequencing has invested very heavily in the development of new technologies. Often the ideas for new technologies for gene sequencing will come from the research sector—universities and institutes—and that's been happening around the world. Then companies will run with a technology to produce their latest set of machines that they'll sell, to hospitals or universities, to undertake genome sequencing. I'm not aware whether any Australian researchers have contributed directly to the improvement in the technologies that have led to that drop in costs. But it has, indeed, been an international effort.

CHAIR: Okay. So I think we can dispense with program 1.1 now. We'll move on to program 1.2, Health innovation and technology. Senator Watt has the call.

Senator WATT: Thanks, Chair. I have some questions about the My Health Record. How many Australians have a My Health Record as of today?

Mr Kelsey: The answer is 5.8 million.

Senator WATT: And—forgive my ignorance—the My Health Record is intended to apply to all Australians, not only people over a certain age. It's 5.8 million of the total

Australian population? Are you still on track for every Australian who doesn't opt out of this scheme to have a My Health Record by the end of the year?

Mr Kelsey: Yes.

Senator WATT: You are?

Mr Kelsey: Yes.

CHAIR: Sorry, Senator Watt, can I ask a follow-up question on your first question?

Senator WATT: Yes.

CHAIR: Is there any skewing in the age range? Is it skewed young?

Senator WATT: Do you mean of the 5.8 million who already have them?

Mr Kelsey: Yes, it is. I might ask my colleague Mr O'Connor to come in—but, from memory, 39 per cent are under the age of 18.

Unidentified speaker: Yes.

CHAIR: Perhaps on notice, could you provide us with an age breakdown? That would be great. Thank you, Senator Watt.

Senator WATT: I'm going to take a punt that the proportion of the Australian population under 18 overall is not 39 per cent, so it's disproportionately weighted towards younger people?

Mr O'Connor: The demographic breakdown is: 54 per cent female, 46 per cent male; 36 per cent are 19 years of age or under; 25 per cent are between 20 and 35 years of age; 25 per cent are between 40 and 64 years of age; and 14 per cent are aged 65 plus.

Senator WATT: Thanks. You said you're still on track for every Australian who doesn't opt out to have a My Health Record by the end of the year. How many people in total do we expect to have a My Health Record by the end of the year? I'm presuming it's the entire Australian population?

Mr Kelsey: It's the entire Australian population and those who are resident in Australia and therefore are eligible for either a Medicare card or for a veterans' card.

Senator WATT: Do you have a number for how many that is?

Mr O'Connor: The number at the moment—which we'd need to check—is approximately 25 million.

Senator WATT: Yes, I was thinking it would have to be around about that. So about a quarter have currently got one?

Mr O'Connor: Correct.

Mr Kelsey: Yes, that's correct.

Senator WATT: You've got nearly 20 million to go between now and the end of the year. What systems do you have in place to deal with that? That's going to be a pretty massive influx.

Mr Kelsey: Yes, in terms of the technological systems. The program has been running since 2012, and it has been running on the same infrastructure since that point, as it will during the course of the opt-out period and beyond. We have great confidence in the platform on which it's running, which has been tested at that kind of industrial strength. As you'd

expect, we have run a series of tests to more than exceed even imaginable levels of demand for the service to ensure there's no risk of any technology failure in relation to the core database.

Senator WATT: In terms of the opt-out communication campaign that's occurring, you've announced that the three-month opt-out period begins in July. That means that, yes, there's a three-month period in which people who want to opt out of having this My Health Record have the opportunity to do so?

Mr Kelsey: Correct.

Senator WATT: That's a three-month starting in July?

Mr Kelsey: Yes.

Senator WATT: Is there a public information campaign underway or planned to inform Australians of that right?

Mr Kelsey: Yes. There is a very comprehensive communications plan that was informed in its design by the experience of two opt-out trial site pilots that were run by the Department of Health in 2016, and the communications exercise will deliver, to all Australians, the opportunity to be aware of their rights to opt out and, if they wish to, to opt out. We can give you all the details of that campaign if you'd like.

Senator WATT: Yes. That would be good.

Mr O'Connor: The campaign itself is very much delivered through some of our partners. So we have contracted with 31 Primary Health Networks to conduct community engagement activities throughout that three-month window. One of the key learners from the trial sites was not to start that communications campaign too early. So we will launch that campaign on 16 July. Within the PHN remit, we've contracted them to deliver over 1,000 events throughout that three-month period, and that will happen right across the country.

In addition to that, information will be made available in over 15,000 healthcare locations, including every GP practice, community pharmacies, and public and private hospitals. We've also worked with Aboriginal health services and their organisations to ensure that the communications are in those environments as well. We've also contracted with other organisations, including Australia Post, whereby there will be information in 3,600 Australia Post outlets that will reach over two million Australians throughout the three-month period. We've also worked with the Department of Human Services, so we will ensure that all their access points have the relevant information and the services there provide 80,000 contacts a day. We've also arranged that it will go out with any communication from DHS throughout that three-month period—there will be information within letters that will go to 3.2 million people. There will also be information on the DHS website and Medicare online. I've got quite a lot of detail.

Senator WATT: Is there any media campaign intended?

Mr O'Connor: Yes. This will be supplemented by targeted media activities which will be delivered at a regional and local level. We will work through five PHNs in particular to deliver that campaign so that those processes are in place. In addition to that, we're also advertising within other trade magazines, like *Australian Doctor*. Similarly, we have put in place arrangements with the pharmaceutical organisations, in particular, and Chemist

Warehouse and Terry White Pharmacies, whereby there will be information going out through 20 million copies of their magazines. In addition to that, we've put in place arrangements with peak consumer organisations; there are formal agreements in place there. Some of those organisations are the Consumers Health Forum of Australia, Carers Australia, Australian Council of Social Service, Arthritis Australia, Asthma Australia. I could go on; there's quite a comprehensive list there.

Senator WATT: Is the media campaign going to involve TV, radio and social media?

Mr Kelsey: Contrary to some of the press reports that you will have seen recently, there is going to be paid media for My Health Record. The essence of this program was designed to sustain the context of the opt-out pilots. There's a publicly available evaluation which very clearly says that want people want with this rather complex message around opt-out is to be able to talk to a care professional in the first instance and otherwise to a trusted advocate in their community network. That has been the focus of the work we've been doing. But, to complement that, yes, we are doing paid media, and we will actually, in certain circumstances, also be doing paid television advertising, particularly for Aboriginal and Torres Strait Islander communities. We will be using national television to do that. But, generally speaking, the research has indicated to us very clearly that there are other, more effective approaches to ensuring people are really aware of their rights than national television. But we will be doing radio and we will be doing paid newspaper advertising. Because of the absence, in a way, of national platforms, those adverts will appear through regional and/or local media.

Senator WATT: Okay. What's the anticipated cost of the information campaign overall?

Mr Kelsey: The total budget is $25 million?

Mr O'Connor: Yes, the total budget for the communications is $27.75 million. We have already said that a key component of that is in relation to providing education, support, training and information to providers, and we're writing to every single provider across the country and providing training to those as well. There is a budget there allocating $55 million.

Senator WATT: Is that in addition?

Mr O'Connor: That's in addition. And in addition to that as well, one of the key learnings from the trial sites was around the contact centre, so we're enhancing our services around the contact centre. We have put in place an additional 23 specialised services to support hard-to-reach and hard-to-service communities, and within that there's a budget of $34 million, which also includes the technical side of the opt-out portal for consumers to opt out.

Senator WATT: What was the $27.75 million for?

Mr Kelsey: Public communications.

Senator WATT: Is the paid media aspect of the campaign contained within that 27.75?

Mr Kelsey: Yes. That's $4.8 million.

Senator WATT: So, all up, we're talking over $100 million for this public information campaign?

Mr Kelsey: And associated activities to, for example, ensure that care professionals are able to—

Senator WATT: Sure. Yes, I'm not suggesting—

Mr Kelsey: Yes.

Senator WATT: And you're confident that that's going to reach every Australian?

Mr Kelsey: I'm confident that we've done everything we can to ensure that every Australian has the opportunity to learn about the My Health Record and their right to opt out, and we are monitoring the degree to which awareness follows that opportunity. We will intervene if there are communities that seem to have less awareness than others as we go through the opt-out period. But I should also stress that, if for some reason somebody is not aware of their rights to opt out during the opt-out period, they can cancel their My Health Record subsequent to the opt-out period at any time.

Senator WATT: That was going to be one of my later questions, actually. So you can opt out after the expiration of that three-month period?

Mr Kelsey: You can cancel your record.

Senator WATT: Got it.

Senator DI NATALE: Can I follow up? What does cancelling your record practically mean?

Mr Kelsey: What it practically means is that, when opt out occurs, if you haven't opted out—and I should also say for clarity that there is a three-month period during which people can exercise their right to opt out—there will then be a month during which we reconcile paper forms, and we're providing paper forms to those who, for example, don't have access to the internet or don't wish to, and at that point, records are created. What that means then is that you will have, as it were, an account, but no data will be in it. In order for that account to start being populated with health information, either there will be an episode of clinical care or you yourself will activate the account as you wish. From that point onwards, data according to your engagement clinical services or your willingness to upload information yourself will then populate. So, in the event of cancellation after opt out, if you have any data in your record—and people may not, because they may not have had an encounter with a health provider or have chosen to activate it themselves—

Senator DI NATALE: Do you mind if we prosecute this here?

Senator WATT: No.

Senator DI NATALE: So, practically, you've got this three-month window where you can opt out. Let's say you miss the window and two months later you think: 'Hang on. I forgot to do that thing I was supposed to do.' Will any data be downloaded into your account? I understood that NDS and PBS data would be.

Mr Kelsey: Not unless the account's been activated, and the only way in which the account can be activated is by yourself or by you having a clinical interaction if you haven't opted out.

Senator DI NATALE: So you could get hit by a train and end up in an emergency department and you haven't opted out. What will then be activated—two years of MBS and PBS data? Is that correct?

Mr Kelsey: That's one of the reasons why opt-out is so strongly supported by the clinical community or clinical leadership—for exactly that scenario. In emergency medicine, it would

mean that you wouldn't have had to do anything, but your physician would be able to upload a discharge summary into the—

Senator DI NATALE: I understand that. I'm getting to the point of somebody who doesn't want this, for whatever reason, ending up having a clinical encounter where they haven't got the capacity to say: 'Actually I wanted to cancel this. I don't want you to have access to my information.' If that clinical encounter is somebody in, as I say, a hospital setting, what would automatically occur at that point?

Mr Kelsey: At the point at which the emergency physician or whoever would upload the discharge summary to My Health Record, that would activate the account. At that point, two years worth of MBS and PBS data would start to be uploaded. At any point, what's called the recipient of the record, or the health consumer, can switch off that feed of MBS and PBS data if they choose to, in order to keep their My Health Record alive, as it were. One of the things that it's really important to recognise is that, even after opt-out, for every document type you can withdraw your consent from that document being uploaded to My Health Record, which includes MBS and PBS data.

Senator DI NATALE: And you can retrospectively wipe all that information?

Mr Kelsey: Yes, correct.

Senator DEAN SMITH: I want to go to some comments you made in your address to the National Press Club. In that you talked about the framework around secondary use. Can you just explain that to us? I'm particularly interested also in your comment about ensuring that every person would be able to choose whether or not they wanted their information used for secondary-use purposes. I'm keen to know how the consumer maintains authority over that. In particular, I'm also keen to understand what authorities might be able to override a consumer's desire to have their information not used for a secondary purpose, or secondary use, as you call it.

Mr Kelsey: The framework, of course, is the responsibility of the Department of Health, so I perhaps can hand over to the secretary.

Ms Edwards: I might start the answer. The secondary-use framework obviously is designed to govern the circumstances where all of the data contained in My Health Record, which accumulates over time, could be de-identified and then used for important research purposes. That's something that's heavily supported as a real key source of incredible data, but we need to be very careful—

Senator DEAN SMITH: Research purposes for medical research?

Ms Edwards: Medical research. The framework sets out the basis on which that might be accessed in the future, once there is data. We don't think that's going to happen very soon. Obviously it'll take a while for My Health Records to be created and populated, so there's time for us to make sure we've got the systems in place. But it's very important to release the framework in advance of the opt-out period, which happened on 11 May. The headline items in that are: the data custodian will be the Australian Institute of Health and Welfare, a very reputable, independent organisation to be custodian of the data; data will be able to be released for public health and research purposes only and under no circumstances for solely commercial purposes: there will be no release to insurance companies—

Senator DEAN SMITH: 'Solely commercial'—so it could be jointly commercial?

Ms Edwards: Potentially, but certainly not to an insurance company for any purpose such as use by an insurance company. It's got to be for health and research.

Senator GRIFF: So drug companies would be acceptable?

Ms Edwards: A drug company which is getting the data for the purpose of research which is going to, for example, create a life-saving medicine might be acceptable, but it has to be for that purpose. It is important to say that there will be linkage available to other data, potentially through AIHW, but only the de-identified final product data would be released. Those are the key headline items in the framework, and there's a very complex governance structure being set up, led by the AIHW, to make sure that the framework is adhered to and that privacy is paramount in the use of this very rich data source for the benefit of Australians going forward.

Senator DEAN SMITH: Where does the authority sit to release the data? Who makes that decision and what's the governance that sits around that decision-making process?

Ms Edwards: I might refer you to the framework.

Senator DEAN SMITH: I can have a look at the framework after—

Ms Edwards: Obviously it will be much better than me in terms of summarising it.

Senator GRIFF: Ms Edwards, while you're looking at that, if you've got a record, are you able to say you don't want it to be used for secondary purposes, for instance?

Ms Edwards: Yes. Mr Kelsey might be able to explain the details, but before the opt-out period you will be able to say no to secondary use of data.

Mr Kelsey: Just to explain, amongst the privacy controls within the My Health Record, there will be a new privacy control added which allows you to express a preference to withhold your consent for data being used for any secondary use at all. That will be available to people with a My Health Record from the beginning of the communications exercise around the opt-out period. So it will be available in the next couple of months, even though, as my colleague says, data won't flow for some time.

CHAIR: Can I jump in there? How many people have exercised their right to alter their settings in that way? Do we know?

Mr Kelsey: The functionality hasn't yet been released into My Health Record because we were awaiting for the framework to be published.

Senator WATT: Aside from, essentially—

Senator DEAN SMITH: Don't get too far ahead, because I am still interested in my question. Who makes the decision? Is the decision disclosed to the broader community? I'm interested in the governance that sits around that.

Ms Edwards: The final decision will rest with the data governance board which will be established with the AIHW.

Senator DEAN SMITH: Is it a subset of the AIHW board, or are they one of the same thing?

Ms Edwards: I might have to take the detail of how it operates on notice.

Senator DEAN SMITH: How is the board appointed?

Ms Edwards: It will be comprised of representatives from the AIHW, from the agency and a range of independent experts, including from population health, epidemiology, research,

health services delivery, technology, data science, data governance and privacy and consumer advocacy. The board will oversee the development and operation of all secondary use information.

Senator DEAN SMITH: When the board makes a decision to release the data for research purposes, will that be publicly disclosable? Is there a public reporting mechanism there?

Ms Beauchamp: I think there are a number of processes to go through first. Data will not immediately flow from My Health Record to the AIHW. I think the AIHW ethics committee will first consult with stakeholders on the planned ethics and approvals process, particularly to ensure the protection of individual privacy. Then the use, in terms of the framework, will be governed by the board, and the board will release regular statements about data availability and quality. So it will be fairly transparent. But I think there are a few processes to go through beforehand to make sure that we get it right and protect the privacy interests of individuals.

Ms Edwards: I hesitate in answering the question in detail. It's obviously for the AIHW to establish the board and set its processes. Definitely the case is that it will be a transparent and appropriate public process.

Senator DEAN SMITH: That's all for the moment from me.

CHAIR: We do have more questions in this area, so we are going to have to come back after lunch. We will call a halt. We'll suspend a couple of minutes early and we will resume at 2 pm.

Proceedings suspended from 12:58 to 14:00

CHAIR: We will resume with the Health Portfolio. We are in program 1.2: Health, Innovation and Technology, including the Australian Digital Health Agency.

Senator WATT: Before the break, we were talking about the information campaign that you're going to be running to make people aware of their right to opt out of this health record and it emerged in some of the other questioning that, apart from having the right to opt out altogether, people will have the opportunity to say that they don't want their information used for, I think you said, secondary purposes. And I can't remember whether we ended up getting a full list of the kinds of secondary purposes that will be recognised? I think we talked about for medical research. What are the sorts of categories?

Ms Edwards: That's a matter for the department. The full framework is set out in the second-year's framework, which has been made public and we can table a copy if you would like. I would refer you to that. And, as I mentioned, the data custodians are AHW, so a lot of the processes and so on will be worked out by them as to how the data governance board of AHW will make the decisions. But full information about the framework is available publicly.

Senator WATT: I'll have a look at that then. This might be in the framework as well, but I'm just interested to know, aside from the ability to opt out all together and the ability to effectively opt in by not opting out but saying you don't want it used for secondary purposes, are there any other ways that people can, in some way, limit the use of their health records?

Ms Edwards: This may be something that I have to refer back to the agency. As I understand, at the moment, it's a matter of the functionality to do it, and we're starting out with opt-out completely but, perhaps down the track, we would have. Is that right?

Mr Kelsey: As we discussed before, there is an option to withdraw consent from the use of data for the secondary uses you've discussed. But there is a series of privacy controls in the legislation in relation to its primary use, where you can restrict other people's access to your medical information in the My Health Record. Perhaps I can ask my colleague.

Ms McMahon: There is a range of privacy controls that consumers can exercise. One is controlling which health operators can access any information in the My Health Record, and they can set a record access code on their record and get an SMS alert if someone tries to access that record, and they can provide that access code to a healthcare organisation to provide that access. Beyond that organisational control, a consumer can actually put a mask on particular documents within the My Health Record that they do not want visible to healthcare providers involved in their care and they can do that at any time.

Senator WATT: I imagine it's a bit of a balancing act. You've got to undertake this public information campaign to make people aware of the right to opt out while, at the same time, I presume you are not trying to scare people off; your preference is for them to opt in. Is there any risk that making the opt-out process too prominent could cause people to opt out unduly?

Mr Kelsey: Let me be absolutely clear: the agency, as such, the system operator, has no opinion about the levels of opt out and it's certainly not expressing an opinion about whether an individual should or shouldn't opt out. Our job is to ensure that all Australians have the opportunity to be aware of their rights and to know how to opt out if they choose to.

Senator WATT: How many people have registered to get instructions on the opt-out process to date?

Mr Kelsey: I will just have to get advice on that.

Mr O'Connor: There are just over 11,000.

Senator WATT: I didn't even know that there was such an ability. So, if someone wants to opt out, is there the facility right now to register to find out how they go about doing that?

Mr Kelsey: Yes, and we will email them when the opt-out process is active, which is 16 July.

Senator WATT: That was my next question.

CHAIR: When you say 'register', is that 'I want more information'?

Mr Kelsey: You can go on to our website and you can leave your email address there if you wish to be informed of the moment when the opt-out process is active.

CHAIR: So those people haven't made a decision to opt out; they've made a decision to be kept informed?

Mr Kelsey: Correct.

Senator WATT: Those people have not yet received instructions on how they can opt out?

Mr Kelsey: No.

Senator WATT: That will happen—

Mr Kelsey: On or very close to 16 July.

Senator WATT: I don't think you answered this before the break. What will the opt-out process actually look like?

Mr Kelsey: There are three ways in which people can opt out and, again, they have been designed in the context of the learning from the opt-out trials. The first is online, the second is via the call centre and the third is that, where appropriate, particularly in remote and rural Australia, there will be the opportunity to opt out on paper forms.

Senator WATT: The same form to be completed via whichever of the three mechanisms people use?

Mr Kelsey: Yes.

Senator WATT: Is it a big form or a short form?

Mr Kelsey: It's a very simple process. We've worked very hard to ensure that that is the case. You need some items of identification—a driver's licence, for example, or a passport—to be able to opt out of the My Health Record.

Senator WATT: There's really only one question on the form: do you want to opt out—tick 'yes' or 'no'?

Mr Kelsey: Essentially, yes.

Senator WATT: Has there been any modelling done to establish the number of people that you expect will opt out?

Mr Kelsey: No.

Senator WATT: I think we worked out that there's about 25 million Australians who would be, if you like, eligible for a My Health Record, but we don't really know how many we're expecting to opt out?

Mr Kelsey: No. The basis of this project is to accelerate the clinical benefits that have been identified and associated with the sharing of key information about a person's health. Our objective is to identify and accelerate those benefits. Those benefits are not contingent, really, on the rate of opting out, so there is no notional target rate. The important thing is that we have made every reasonable effort to communicate the rights people have to opt out to the community at large in Australia.

Senator WATT: What proportion of people who participate in the trial sites opted out?

Mr Kelsey: One point nine per cent.

Senator WATT: And how many people participated in those trials?

Mr Kelsey: Around a million.

Senator WATT: Would you expect it to be a fairly similar proportion?

Mr Kelsey: I wouldn't have any opinion.

Senator WATT: I suppose the effectiveness of the record is dependent on the number of people who sign up?

Mr Kelsey: There was one other important component of the government's evidence base around moving to opt-out registration: the results of a very important experiment in the Northern Territory over a number of years in which shared information was made available to clinical practitioners. In that case, after the evaluated review was undertaken, what made clinicians build it into their work flow is that more than 51 per cent of the community had an electronic health record. It's a different circumstance, but that was the tipping point at which

the clinical benefit started to accelerate, because GPs and others routinely would look at the record that an individual had.

CHAIR: If I could put it into the frame of vaccinations, you get an individual benefit, but there's also a community benefit: a herd immunity. I would assume that keeping these records would be similar. Obviously, if one person signs up, that person gets an individual benefit, but the more information we have flowing into the system will also be of benefit?

Mr Kelsey: Yes. Certainly that's true for secondary uses and the analytical purposes we talked about externally, but, as far as the primary use goes, which is the purpose of this current opt-out, I think the benefit is that, if you have one, you are likely to be safer in the case of an emergency, for example, than if you don't.

Senator WATT: One point nine per cent of the one million people who participated in the trials is roughly about 20,000 people and at that rate, across the whole population, you'd be talking about 500,000, if it were that rate.

Mr Kelsey: Yes, that sounds about right.

Senator WATT: I think it's been reported that about two-thirds of people in those trial sites didn't know that they'd been given My Health Records. Is that right?

Mr Kelsey: The evaluation report has actually been published. We can provide you with links that contain all those figures. I think that sounds about right. Yes.

Senator WATT: What public information campaign did you undertake within the trial sites before that?

Mr Kelsey: Again, that may be for the department. The Department of Health ran the opt-out trials originally, but I should say that the learning, the evaluation of that communication activity, is the basis upon which we have designed the national approach to ensure that we do achieve total and comprehensive reach in the opportunity to learn about My Health Record and the right to opt out, and significantly raise public awareness also.

Senator WATT: Is there someone from the department who can tell me what public information campaign occurred in the trials?

Ms Edwards: We might have to take that on notice, because it pre-dates the current officers in the roles and it would be more accurate to take on notice the detail of what happened for the trial sites.

Mr Kelsey: But it is in the public domain, Senator.

Senator WATT: How many people in the trial sites told you, after the opt-out period that was provided for, that they didn't actually want a My Health Record?

Mr Kelsey: Well, the 1.9 per cent opted out of having a My Health Record.

Senator WATT: So, you had an opt-out period in the trials?

Mr Kelsey: Yes.

Senator WATT: And 1.9 per cent of people opt out in total. What I'm interested in is how many people chose to opt out after the opt-out period closed off.

Ms McMahon: To cancel their record?

Senator WATT: Yes, I suppose that's the way to put it—to cancel their record.

Mr Kelsey: I actually don't have that to hand.

Ms McMahon: We have had anecdotal feedback from two regions—Nepean Blue Mountains and Far North Queensland—that there's actually been the opposite effect: healthcare providers have had consumers come to them and say that they now want a record, and they have actually chosen to opt in since then.

Senator WATT: They're people who chose to opt out and have then reconsidered?

Ms McMahon: And are now more comfortable, as time has moved on.

Senator WATT: Actually, I was going to ask about that before. For people who do that—let's say for argument's sake that someone opts out and then two years later they decide, 'Oh, actually I do want to have this record after all.' Will they have an up-to-date record? How will that—

Mr Kelsey: Well, the answer is that if you choose to opt out there is no data, obviously. There is no record, so no data flows into it. If subsequently you choose to have a record created, the record will start from that date, with the exception of two years worth of PBS and MBS flowing at that point. So yes, you will lose potential health information during the period of opt-out.

Senator WATT: Yes. So, the data that's accumulated within that, say, two-year period is not stored somewhere only to be loaded in at a later date?

Mr Kelsey: No, and this is a really important point: there is no system in Australia that does that job. People may have the impression that somewhere, somehow, their medical history is indeed being recorded in a way that can later be uploaded into the My Health Record. The point of the My Health Record is that that, unfortunately, does not exist and, as a result, people are presenting into hospital having to remember their histories, having to remember their medicines. Hence My Health Record is being developed to fill that gap. So yes, the answer is that until you have a My Health Record there is no retrospective means by which it can find health information about you.

Senator WATT: And you've taken on notice the number of people who decided to cancel their records after the opt-out period in the trial sites?

Mr Kelsey: We can certainly have a look for that information.

Senator WATT: If you could, that would be great. And what proportion of people in the trial sites set up PIN numbers to control who had access to their personal information?

Ms McMahon: We don't have the breakdown in the trial sites, but less than a 10th of one per cent of people have applied privacy controls within their record. We can see if we can get you a breakdown within those regions. We may not be able to, but if the data is available we'll provide it.

Senator WATT: So, having a PIN is one of several privacy controls that can be—

Ms McMahon: Correct.

Senator WATT: But all up it was less than one 10th of one per cent?

Ms McMahon: Yes.

Senator WATT: Has there been any modelling to predict how many are likely to choose those options in the full rollout?

Mr Kelsey: No.

Senator WATT: But would you expect that it would be a fairly similar percentage?

Mr Kelsey: I wouldn't venture an opinion. The important thing is that we do communicate that those opportunities exist for people, and one of the primary focuses of the improved design of the My Health Record over the last couple of years has been to make sure that that is the case. I don't know whether you've seen it, but the means by which you are made aware of those controls I think is fairly clear, and certainly their exercise is straightforward.

Senator WATT: That's obviously a pretty low proportion—one 10th of one per cent. Do you think that is some indication that people aren't concerned about their privacy? Or does it more indicate that they weren't really engaged with the opt-out process? What do you think?

Mr Kelsey: It's consistent with similar international programs. On the whole, people in the context of, say, the English Summary Care Record system and the My Health Record in Australia are engaging in the initiative in order to make sure that their medical information is available, particularly in emergency circumstances, to a care professional. So, whilst those rights exist, it doesn't surprise me that people on the whole are choosing to not necessarily exercise them.

Ms McMahon: Can I clarify that that proportion applies to the entire five-plus million people who have a My Health Record, not just those who were involved in the opt-out trials.

Senator WATT: I see.

Ms McMahon: So four-plus million people have opted in to have a record created for them.

Senator WATT: Okay, thanks. Have you got any information about the clinical take-up rates of the system?

Mr Kelsey: We do.

Mr O'Connor: In relation to the uptake by provider organisations, as of 29 April there were 11,238 provider organisations registered for My Health Record. This has increased at a rate of approximately 120 each month. The breakdown of that figure is 6,372 general practice organisations, 1,831 retail pharmacies, 802 public hospitals and health service facilities, 183 private hospitals and clinics, 186 aged-care registration service organisations, 48 pathology and diagnostic imaging services, and 1,475 other healthcare provider types.

Senator WATT: Once it's fully rolled out and all Australians, other than those who have opted out, have a My Health Record, will provider organisations—GP services, aged-care homes and others—have to register in order to—

Mr Kelsey: No.

Senator WATT: Can you explain how that works?

Mr Kelsey: It's not compulsory for provider organisations to connect to the My Health Record.

Senator WATT: But, to date, a bit over 11,000 have.

Mr Kelsey: That's correct.

Senator WATT: And you have to connect to the record in order to be able to access the information that's on the record, I presume?

Mr Kelsey: Correct.

Senator WATT: Do you know how many provider organisations haven't connected?

Mr Kelsey: I don't, I'm afraid.

Senator WATT: Is there an information campaign being undertaken to encourage providers to connect?

Mr Kelsey: Yes. One of the key prerequisites for the public information service that is being launched on 16 July was a very significant level of mobilisation with the provider community. With our colleagues in the Primary Health Network, in state and territory governments and in peak bodies—which include the AMA, the Royal Australian College of General Practitioners, the Pharmacy Guild, the PSA, rural and remote specialists, GPs and others—we have undertaken a very comprehensive program of education and awareness with Australian providers so that, by the time we go to public communications, all GPs and pharmacists will have been trained in My Health Record. In many parts of Australia, that's already the case as activity has increased over the last few months. That is so that they are able to understand what My Health Record is and make a decision about whether they wish to connect but, crucially, also support and counsel their patients in the event that they are asked about the opt-out opportunity.

Senator WATT: I saw some media reports last year that said only about 263 specialists had connected to the system. Mr O'Connor, in those figures that you provided me, were specialists picked up in any of the categories you listed?

Mr Kelsey: I think that referred to specialist organisations. So that's not the number of specialists but the number of specialist organisations.

Senator WATT: Do you have the comparable figures now?

Mr Kelsey: For specialist organisations? No.

Senator WATT: Could you take that on notice?

Mr Kelsey: Yes.

Senator WATT: To the extent you can work this out, I'd be interested to know what percentage of the number of specialists overall in Australia that represents.

Mr Kelsey: Yes.

Ms McMahon: I will add that there are many specialists who work in the public and private hospitals who also have access through those systems. So, when we're looking at specialist organisations and those employed in those organisations, it will exclude the many specialists working within hospitals accessing the record.

Senator WATT: By 'specialist organisations' are you talking about some of the colleges?

Mr Kelsey: No, we're talking about specialist organisations outside hospital. Organisations can be large aggregations of different specialists in consulting rooms.

Senator WATT: Sure. Does the system still rely on the uploading of PDF documents?

Mr Kelsey: The vast bulk of data in the My Health Record system comes from the MBS and PBS server systems, which are atomic data. Other forms of data are PDF.

Senator WATT: What sorts of forms of data are PDF?

Mr Kelsey: That might be a shared health summary or a discharge summary from a hospital, a pathology report, a radiology report and so on.

Senator WATT: How many My Health Record holders have been affected by unauthorised access so far?

Mr Kelsey: Well, none have been affected. Sorry, do you mean—

Senator WATT: Do you have any data on the number of incidents of unauthorised access to people's My Health records?

Mr Kelsey: In the year 2016-17, we have reported six instances which required reporting, or we voluntarily reported, to the Information Commissioner. In this year, not yet published, we have reported three instances—and perhaps I can ask my colleague to give you details of those.

Ms McMahon: In year 1, which was last financial year, four of the six instances related to fraudulent Medicare claiming—so someone made a fraudulent claim and, through that process, was able to access the My Health Record. Two related to an administrative error where they were processing a newborn Medicare registration form and it resulted in the incorrect consumer on the Medicare card being linked to that record. In this financial year to date, two incidents related to Medicare fraud and one related to the same administrative error.

Senator WATT: Has anything occurred, particularly since the Medicare fraud incidents, to improve the system to try to prevent that sort of thing happening again? Are there learnings from that that are then—

Mr Kelsey: Yes, we constantly work with our colleagues at the DHS to ensure that they are aware of these incidents and can fix and rectify them as rapidly as possible. But none of them, I should emphasise, have resulted in any clinical harm to anybody.

Senator DEAN SMITH: I have a couple of questions. Of the 1.9 per cent that chose to opt out, what were the reasons or justifications that were given?

Mr Kelsey: Again, that's in the published report. The Department of Health obviously undertook that piece of work and it would be more appropriate for the department to comment. But there were a variety of reasons people gave, which are available in the public document.

Senator DEAN SMITH: Does the department want to comment on that?

Ms Edwards: I'm just pulling up the reference to the public report to refer you to. It's a publicly available independent evaluation report, and I'd recommend you go to it rather than have my memory paraphrasing.

Senator DEAN SMITH: I trust you, Ms Edwards! I trust your paraphrasing.

Ms Edwards: Well, on this occasion, I think I'll refer you back to the report. Again, it's predating my time at the Department of Health. We could provide on notice a summary of what it says or—

Senator DEAN SMITH: Yes. Mr Kelsey, there's a fundamental tension here, isn't there, because one of the measures of success of the e-health record would be the number of e-health records that are active over the medium to longer term. How have you ensured that that goal has been properly balanced against the other goal, of ensuring that consumers have control over their health records? I think 'consumer controlled' was the term that you used in

your comments. How have you satisfied yourself that you've struck the right balance there? Privacy considerations are important to Australian consumers. I did just try to have a look at some of the reporting around breaches in regard to privacy around healthcare data more generally, not just in regard to what we heard most recently. But how have you satisfied yourself that you've struck the right balance?

Mr Kelsey: Let me reassure you that the privacy of patients is the paramount obligation we have as system operator. It is the first priority of the act that we are operating. But I would also say that the way that success is measured is not by the number of people who have a My Health Record. In terms of the budget measure that the government announced back in May 2017, the criteria for success is reductions in things like adverse drug events in Australia—which currently run at roughly 230,000 per annum—and things like reduced duplication of diagnostic testing. These are the benefits that were called out in the budget measure which supported the investment in moving My Health Record to opt out. So we're not measuring our success in terms of the number of records created; we are certainly measuring our success in relation to delivering those clinical benefits but also in relation to the effectiveness of the very security controls we run on My Health Record to ensure that people's privacy is protected.

Senator DEAN SMITH: What measurements have you put in place, or are you putting in place, to be able to measure the success—

Mr Kelsey: Those outcomes.

Senator DEAN SMITH: given that people will be moving to these health records sooner. How are you measuring that success?

Mr Kelsey: We have a research program that is run by our chief medical adviser, Professor Meredith Makeham, which has a number of approaches. There are actually five and, if you want more detail, Meredith would, of course, be able to provide that information. But, essentially, they range across looking at behavioural changes, introduced in a scientifically rigorous way in terms of clinical practice, like: does how and when individuals are able to access information about a patient they may not have seen before reduce the number of tests they might order? And it goes through to looking at impacts on Medicare behaviours through analysis of data and so on.

So there are five different approaches, and we have set up a series of research collaborations with universities across Australia and with other partners in clinical practice to ensure that we look at the impact of My Health Record in a very robust and transparent way, but from a number of different angles. So we have a comprehensive approach to research, and that is the basis on which we are evaluating impact.

Senator DEAN SMITH: So that will be established or has been established?

Mr Kelsey: Has been—I mean, yes.

Senator DEAN SMITH: What's the time frame for those research projects?

Mr Kelsey: They deliver at different points on the cycle over time, so there are some short-term outputs which we are expecting later this year.

Ms McMahon: In the next six months we'll get the interim results and early results, but most of the programs run over the next 12 months with options to continue longitudinally.

Senator DEAN SMITH: Great, thank you.

CHAIR: Have stakeholders pretty much universally endorsed this process?

Mr Kelsey: Yes.

CHAIR: So there are no outliers in that respect? The AMA, the royal colleges and the consumer networks have all supported this process?

Mr Kelsey: That's correct, yes. Just to make the point, all the clinical peaks are engaged in promoting awareness and they support the concept of opt out of My Health Record because it will accelerate the clinical benefits that I've described. And those peaks—and I must thank them for their support—include, as you say, the AMA, the college of general practitioners, the College of Rural and Remote Medicine, the Australian Association of Practice Management, the Allied Health Professions Australia group, and the Consumers Health Forum and the Federation of Ethnic Communities' Councils of Australia. We're very indebted to the work that we've done with the National Aboriginal Community Controlled Health Organisation, NACCHO, which has helped us ensure that communications work with Aboriginal and Torres Strait Islander communities are appropriate culturally to those communities, and a variety of others. We have relations with more than 100 national peaks who are supporting the move to opt out. And that reflects, at more local levels, quite literally hundreds of chapters or local organisations affiliated to those national peaks.

CHAIR: Great, thanks. It was important to get that on the record. Senator Griff.

Senator GRIFF: Mr Kelsey, you said 11,238 people had registered?

Mr Kelsey: Providers.

Senator GRIFF: Sorry? That are registered for the system at this stage?

Mr Kelsey: So there are 5.8 million Australians.

Senator GRIFF: No, as in providers.

Mr Kelsey: Providers, yes. Organisations, yes.

Senator GRIFF: Out of that, how many would be medical practitioners per se, like GPs and specialists? You mentioned 6,372 GPs. Do you have a specialist number as well?

Mr Kelsey: I don't think we do. We have the number that was reported earlier by Senator Watt in relation to the number of specialist organisations that are connected.

Senator GRIFF: Do those 11,238 they have functional access, or are they just registered? Are all of those people actively sending you data now?

Mr Kelsey: People obviously send data at different times. They are all capable of sending data.

Ms McMahon: It varies depending on the type of healthcare organisation. For example, we have 1,831 retail pharmacies and community pharmacies connected. Each time they dispense a medicine, a record of that dispensed medicine is automatically sent up. So every single one of those is actively uploading data every day as they dispense medicines to people with a My Health Record. With general practice organisations, there's a type of document called a shared health summary that is curated by a general practitioner, and they curate that record and send it up as often as clinically appropriate. So it's not an automatic process. With hospitals that are connected, as a discharge summary is sent, a copy is also sent to the My Health Record routinely.

Senator GRIFF: How many of those GPs—those 6,372—are actively uploading now?

Mr Kelsey: We don't have the figure with us, but we can provide the figure.

Senator GRIFF: On notice?

Mr Kelsey: Yes.

Senator GRIFF: That would be great.

Ms McMahon: It would be the majority.

Senator GRIFF: It looks like to me like you're going to have a fantastic system with a lot of people registered, because it will be automatic for the majority of them. But, obviously—and this is where your focus is—you will need to make sure as many providers as possible are providing input

Mr Kelsey: Yes, correct.

Senator GRIFF: My understanding is that there are 70,000 medical practitioners, of which 40,000 are GPs and 25,000 are specialists. You've got a long way to go to get all of them actively participating in the system.

Mr Kelsey: Just to clarify: the figure, for example, on GPs is for general practices, not GPs.

Senator GRIFF: Sure.

Mr Kelsey: The vast majority of GPs are connected to the My Health Record.

Senator GRIFF: One thing I've been told is that a big issue is that providers need to have a HPI individual and a HPI organisation and there's a lot of difficulty for them to actually register and to have both of those entered into your system and the process is a bit unorderly.

Mr Kelsey: That's a criticism that's been made for a long time, with some justification. This is the process by which a clinician individually obtains the certification that allows them to use My Health Record and as an organisation. We've been working closely with our colleagues at the DHS, who run that process, and the budget required us to have automated the application process for the individual certification before we start and that it will happen. That will reduce the length of time that it takes for an individual to acquire the current physical certificate, which is usually in the form of a CD-ROM, from days to hours.

Senator GRIFF: That's great. In your National Press Club address last week, which was very impressive—

Mr Kelsey: Thank you.

Senator GRIFF: you mentioned that adverse medical events account for two per cent to three per cent of all hospital admissions. We know that this is particularly an issue for the elderly where there is an issue with longstanding or multiple prescriptions not necessarily being reviewed, leaving them at risk of adverse reactions or taking medications they no longer need. Besides listing medications which have been prescribed and dispensed, how can MHR address this problem?

Mr Kelsey: That's a very good point. I might ask Meredith Makeham, our Chief Medical Adviser, who is a practising GP as well the lead research for the agency, to come to the table. It might be good to get a clinical perspective. That was a comment that was made by a very large number of clinicians in Australia, through their peaks. So last year we introduced

another functionality into the My Health Record—MedView. What that does, for the first time, is aggregate all a person's medicines information to one easy view, so that you can instantly see the history of a person's medicines. This is having a positive impact on dealing with exactly the issue you've just raised. Meredith, is there anything that you'd add from a clinical perspective?

Prof. Makeham: I think that's a good summary. The increasing connections of aged-care facilities, in addition to this, is also very important, so that clinicians can have a view of documents that are potentially uploaded through those facilities through My Health Record.

Mr Kelsey: In some parts of Australia that is already happening. I perhaps recommend to you the example of Berrigan, which is a community in the Riverina area of New South Wales, where local clinical action has seen the connection of the aged-care facility, the local hospital, the general practice and the community pharmacy so that they are all able to share information, and, as a result, improve outcomes for their patients. In Berrigan, with a community of 920 people, 60 per cent now have a My Health Record and all people over the age of 75 have expressed an advanced care plan intention in the My Health Record.

Senator GRIFF: I know from personal experience that GPs don't always go back and reassess whether longstanding prescriptions are still needed, particularly for elderly patients. Is there, or will there be, a capability for MHR to alert GPs that it's time to review a particular prescription after a period of time, for instance, or alert them to any combinations that might cause adverse reactions?

Prof. Makeham: Currently there's no facility within My Health Record to provide alerts of that nature, but it's certainly an improvement that's under consideration and has been suggested by the clinical community.

Senator GRIFF: That's good to hear.

Ms McMahon: Most healthcare providers access My Health Record data through their own clinical information system that's provided by the software industry. Often the clinical decision support, which is the type of function you're describing, is provided in that layer of the software, so often those software packages will provide alerts, reminders and other assistance to general practitioners or others using the data from the My Health Record.

Senator GRIFF: The reason I ask this question is a personal one. I had an experience with a family member 18 months ago where they were hospitalised. They had been with the same doctor for many years and had been popping literally 50 pills every day. When they were admitted into hospital it was a long weekend and they couldn't contact the doctor, so they had no information whatsoever. She was very sick and so they started afresh at the beginning, and that gave this person an extra two years worth of life. They improved dramatically, because they weren't on this big bundle of 50 drugs that they'd been given for the last 20 or 30 years. I think it would be an interesting enhancement or step to have a look at, when someone has been prescribed certain drugs for a long period of time, to then have that kind of review to happen via the system. It'd be good to hear that it's something that could happen in the system down the track. If overseas researchers apply to use the data, how will you ensure adherence to privacy laws and ensure that they won't reidentify the data in any form?

Mr Kelsey: Could I refer that back to my colleagues in the department?

Ms Edwards: Any release of data would be dealt with under the secondary use framework we were discussing, which will be managed by the AIHW. No data would be released that doesn't comply with the law—privacy and all other laws. Data will be deidentified in very sophisticated ways. There is some small prospect for identified data, but that's only with specific consent of the individual concerned. By far, the most we're anticipating is that it'll be required to be deidentified data. The AIHW and all the experts it consults in the context of its data governance board will ensure that the utmost efforts are made to ensure that it's encrypted in an absolutely fail-safe way. That's really at the heart of what's in the secondary use framework: we should be making available deidentified useful data to help the community and researchers, but in a way that absolutely protects the privacy of any particular clinical records.

Senator GRIFF: Mr Kelsey, in your presentation the other day you stated that MHR is a fully consent based system and that sensitive records can't be uploaded by a doctor without a person's permission. Does that mean a GP or specialist will have to seek a person's permission each and every time a sensitive document or test is uploaded?

Mr Kelsey: No. My Health Record is based on the concept of standing consent. Individuals have the right to withdraw their consent, for example from the upload of a pathology report or a radiology report or any document. Once they have a My Health Record, it's presumed that they are giving their consent unless they choose not to.

Senator GRIFF: Is that even for something that's sensitive or that your classifying as a sensitive document? It doesn't matter what kind of document it is; that permission is there automatically.

Mr Kelsey: In some parts of Australia different states and territories have different approaches as to what is permissible, in relation to the upload of sensitive pathology reports, for example. There are existing policies which the My Health Record merely reflects, so there is already a layer of jurisdictional policy in relation to the upload of sensitive data. Beyond that point, content will be uploaded into the My Health Record where currently somebody has opted in to having one, and in future where they've opted out, unless they withdraw their consent from those records being updated. My hope would be that My Health Record as a whole should be a complement to the information resources available to a GP. Remember that most of its records are copies of all the clinical documents—they're copies of documents.

A very important part of the responsibility of a caregiver is that they do counsel their patients on the management of sensitive information. So I have no doubt that when considering a sensitive document or a sensitive test the clinician would advise or counsel their patient to be aware of their right for it not to be uploaded into My Health Record. If they do not opt out of that document being uploaded to My Health Record, they can of course, at any time, exercise the privacy controls that my colleague mentioned, and either put an access code across the individual document or across the whole record or actually mask the document from view altogether.

Senator GRIFF: So the upload system varies? Or it's a common upload system when a hospital or a doctor wants to send data to you? It's a portal of some kind?

Mr Kelsey: Well, no. The software on each of these locations is accredited by us to be what's called 'conformant to the My Health Record'. That means that it's able to connect to the My Health Record and upload documents where it's appropriate to the My Health Record.

Senator GRIFF: Does the system time out? Are there fail-safes? If somebody's got the screen open, got the system open, will it actually time out after a period of time?

Mr Kelsey: Yes. These are all part of the conformance requirements that software providers have to meet.

Senator GRIFF: Thanks.

CHAIR: Senator Di Natale.

Senator DI NATALE: Going back to that, you have the three-month period and you're putting a lot of work into letting people know what's about to happen. But I think we can reasonably expect that, despite your best efforts a lot of people will not be aware that they've had a record established. You said it's basically activated at their first clinical encounter. Can you just talk me through that process? What happens? For example, Joe Blow makes an appointment with their GP in January of next year. It's their first appointment since the October deadline has passed. When does it get activated? Is it the point I go in or is it the time I make the appointment? When does it get activated?

Mr Kelsey: It's the point at which the software in that clinician's practice searches the DHS database to identify your unique health identifier, to which is attached your My Health Record. It's the moment that that software interaction takes place.

Senator DI NATALE: But when does that normally—I'm not a technical person—

Ms McMahon: It's typically when a clinician tries to view the information or when a document is uploaded. Earlier I described how in a community pharmacy the dispense record is sent; that would trigger the activation. If a general practitioner clicked on the My Health Record tab and viewed information—that type of interaction.

Senator DI NATALE: You might see your see your appointment list for tomorrow and you might look up—'I haven't seen person X for a few months and I'll just refresh myself. I know there was an issue last time.' That person might not actually be aware that the health record has been established until they've had the clinical encounter?

Mr Kelsey: That's correct. The whole point of opt out is that—

Senator DI NATALE: I'm aware of it. I know what the point is. I just think that, despite your best efforts, there's going to be a bunch of people who will have no idea that this is happening. That's just the reality, isn't it?

Mr Kelsey: What I said earlier is that, in the event there is someone who doesn't know that they could have opted out, they can then cancel their record any time after the opt-out period has expired. If they haven't had a clinical encounter, there won't be any data in it anyway.

Senator DI NATALE: The MBS and PBS data would be downloaded.

Mr Kelsey: Only when it's activated.

Senator DI NATALE: Yes, but it would be activated when the healthcare provider—

Mr Kelsey: Yes, but if they haven't seen—so, in a situation where I haven't seen a healthcare provider and/or I haven't personally activated the record, there will be nothing in it. So, if you then choose to—

Senator DI NATALE: I'm aware of that. I suppose I'm thinking of a case of—you know, you go and see a GP, and you might have been treated for something that's very sensitive. Even though you're not getting clinical information, you are getting a list of prescription medicines which gives you a good clue as to what's going on. The GP will have that information prior to you having visited them if they've accessed your record. That's the question.

Mr Kelsey: Yes. That's correct.

Senator DI NATALE: And so there will be people who I suppose will be a little surprised. As you say, in some cases they might not actually have seen the record, but in some cases that will have happened—obviously, seeing a prescription from a pharmacist. In the setting of a pharmacy, is there an onus on the pharmacist to say, 'You now have a health record, and any information I enter now will be uploaded'? How is that going to happen?

Mr Kelsey: The Pharmaceutical Society of Australia has published guidelines for pharmacies in which they exactly explain what best practice looks like, which would be a conversation. Similarly, the AMA has published guidance, which is being refreshed at the moment, to support broader clinician understanding of what best practice is.

Ms McMahon: But there's no legislative requirement for healthcare providers to raise awareness amongst consumers. That's our role as system operator.

Senator DI NATALE: Are you encouraging health professionals to have this conversation prior to that?

Ms McMahon: Yes, we are. That's what Tim mentioned.

Senator DI NATALE: You mentioned that there were guidelines. You didn't say what they were.

Mr Kelsey: And so are the peak bodies. The Pharmaceutical Society has published guidance which is put together in consultation with its membership, for example, in order to precisely prescribe what best practice—having a conversation—looks like for pharmacists.

Senator DI NATALE: Do those guidelines reflect that that conversation ideally takes place before the record is—

Ms McMahon: An individual healthcare provider is unlikely to know whether a record has been activated or not until they view it, so a pharmacist, for example, won't know whether the consumer has opted out. So, practically speaking—

Senator DI NATALE: Practically, they'll look at it. The information will be downloaded because it's been activated through that encounter. Then they'll have a conversation with the patient?

Ms McMahon: They'll look at it, and there may be data in it or there may not be.

Senator DI NATALE: Yes. It's good to have a sense of what it looks like when it's actually working rather than theoretical. In most cases you'd expect the information will be downloaded at the point of the clinical encounter because, as you say, they've got to download it to enter the information.

Mr Kelsey: Or, indeed, as we know from Berrigan, the individuals themselves have the ability to upload documents that they want to, including an advanced-care directive, for example, and only they are able to do that. That's one reason why people would want to activate their record other than in the case of a clinical encounter: to take advantage of some of those self-service functionalities.

Senator DI NATALE: I'm thinking more of a person who doesn't know this thing is happening, finds out about it and says, 'Oh, I don't want to be part of it.' I just want to know what protections there are. At that point during the clinical encounter, the person would say, 'Actually, I don't want to be a part of this.' What happens next? Say they're at the pharmacy.

Mr Kelsey: There are a number of things. If they wish, they can go online and locate their My Health Record. They can then delete it altogether. They can take advantage of the privacy controls to, say, put in a PIN number or delete the document they don't want to be present in their record. There are a number of options open to them. They can also do that via the call centre in relation to deleting the record itself.

Senator DI NATALE: Okay. I suppose they can't do it within the clinical setting, really. It's going to be an action that they take afterwards.

Ms McMahon: That's right. They need to contact us through one of those channels partly because we'd have to verify their identity to perform that action.

CHAIR: It's completely understandable you don't want medical practitioners being able to alter people's records without their consent. How about if a practitioner accidentally uploads something? Can they remove that, or do they have to seek the patient's permission?

Ms McMahon: They can remove that. The conformance software all has a requirement that an uploaded document can also be removed if it was incorrectly uploaded.

CHAIR: Okay.

Senator DI NATALE: So just what happens after that point is the person's record is effectively wiped if they decide they've don't want to be part of it, and no-one else will have access to the information except for the information that was available through the previous clinical encounter?

Mr Kelsey: That's correct.

Senator DI NATALE: I will ask you about the discharge summaries and the GP health summary. The GP health summary is likely not to be in PDF format. I don't know what the technical language is, but it will be in computer speak?

Ms McMahon: It will be CDA format.

Senator DI NATALE: CDA is the code or something that's used, is it?

Ms McMahon: Yes.

Senator DI NATALE: But when discharging someone from hospital, I can't believe we're still in the era of these awful bits of scribble that tend to be distributed after a hospital admission. Why isn't there a similar code within the discharge summary environment?

Ms McMahon: There is. The vast majority—around 95 per cent—of hospital discharge summaries are in CDA format. Some are PDF. They're not a scanned PDF with scribbles on it; they're a tight readable document but in a PDF format rather than CDA.

Senator DI NATALE: Will that be because it will have been through the medical records department, encoded and—

Ms McMahon: It's usually just because of the capability of the software used by that particular hospital, public or private. Most hospitals, especially in the public estate, are uploading the structured data records which are the CDA formats.

Senator DI NATALE: Why are they in PDF format? Is that the same for the GP summaries?

Ms McMahon: No, the shared health summaries are all in CDA format. There are no PDF shared summaries.

Senator DI NATALE: Why are they in PDF format if they're using the same code?

Ms McMahon: It's the technical limitations of the software package chosen by the particular hospital, which hasn't got the capability to upload a structured document in CDA format.

Senator DI NATALE: You're moving in that direction, obviously. Are you hoping that changes over time?

Ms McMahon: That's right. CDA formats have structured data that allow for decision support—the sorts of features that Senator Brockman mentioned earlier around alerts and other things—rather than PDF documents.

Senator DI NATALE: Can I ask about the secondary users? A couple of people have raised questions of insurance assessments, employer assessments and so on. As an individual, you can choose what you want other health practitioners to see. Is that right?

Mr Kelsey: To be absolutely clear, only a registered health practitioner treating you is authorised to look at your record, and that's the point of both the conformance and certification of individuals and organisations. So that would mean anyone wanting to access data for any other purpose would have to seek your individual consent for that or would have to go through the framework.

Senator DI NATALE: What about a pre-employment medical, for example? You might not want your prospective employer to know you've been treated for a mental health issue, a sexual health issue, maybe a sensitive issue.

Mr Kelsey: Unless you gave them your consent, they would have no access to My Health Record.

Senator DI NATALE: So, for example, can there be pressure applied on the individual to disclose that information?

Ms McMahon: The My Health Record's act specifically lists authorised uses of the information in the My Health Record which relate to the primary purpose, which we're discussing at the moment and secondary use, which we've discussed. Releasing that information for a purpose that's not related to care or to one of the authorised secondary uses would be an unauthorised disclosure of that information.

Mr Kelsey: Unless you gave your consent.

Senator DI NATALE: So, again, individuals can clearly state they don't want information for insurance purposes or for pre-employment purposes to be accessed by a prospective employer?

Mr Kelsey: The only way that data could be visible in those circumstances would be if the consumer themselves had provided that information. There's no facility for those parties to have any other reason to access one's record.

Senator DI NATALE: The concern is, if you're not doing that, you're hiding something. If it's something for insurance purposes, compensation purposes, what are the protections in that sense?

Mr Kelsey: I think that's a broader sort of social question which would go to broader criminal conduct in relation to forcing people to do things against their will.

Senator DI NATALE: But the act specifically outlines purposes for which the information can be used and the secondary purposes—

Mr Kelsey: Yes, that's correct.

Senator WATT: Has any consideration being given, either by the agency or by the department, to putting in place some sort of new penalties against people who inappropriately force the giving of consent?

To take Senator Di Natale's pre-employment situation, it's not difficult to envisage a situation where someone might be pretty desperate for a job and a prospective employer applies pressure to them to consent to the release of the information. Sure, it can't happen without their consent, but in this evolving world of data and privacy has any consideration been given to new precautions to stop that sort of abuse?

Ms Edwards: I would make the point that forced consent is not consent. Going back to first principles, if anyone is coerced into giving their consent I think there would be a good argument that that is not consent at all. There are very strong penalties in the act against unauthorised use, which I can take on notice to refer you to the detail of. Certainly, in coming up with the legislation and all the rules and the workings we do, there is absolute primary consideration given to privacy and so on. I will take away the point you've made and check it out.

Senator WATT: Thanks.

Senator O'NEILL: Are you aware of the recent report of the Parliamentary Joint Committee on Corporations and Financial Services inquiry into the insurance sector? We received evidence from the AMA and the Royal Australian College of GPs of very significant and frequent demands from insurers for the entire record, with the imprimatur of a tick on a form signed many years previously which basically gave them the permission you are talking about—permission to access those full records. In fact, the AMA sat in a room not far from here and said that 100 per cent of the inquiries they received were requests for the entire health record to be handed over. Is the department aware of that and recommendations that have been raised, and of current conversations that are happening between the Financial Services Council and the Royal Australian College of GPs around mitigating this problem from both sides—the request side and the easy delivery of the information as a lump sum?

Ms Edwards: I am not personally aware of it. I am sure my colleagues would be.

Senator O'NEILL: Can I alert you to that.

Ms Edwards: I will certainly take it away for our team and the Digital Health Team to have a look at those recommendations and comments.

Senator O'NEILL: There is work to be done in that field as well, to provide protection here.

Ms Edwards: Thank you, Senator.

CHAIR: Senator Smith.

Ms Edwards: Can I return to your question from before, Senator Smith. I didn't want to let down your confidence in me! I have found the reference to opt-out reasons. It appears on page 243 of the report, at table 3. The top three reasons in the North Queensland and Nepean-Blue Mountains areas for opt-out were 'I have no use for digital health record', 'I prefer to manage my medical records on my own' and 'I prefer that my doctor manages my medical records'. The report comments that, in talking to those people, additional communication or a longer period of communication may well have overcome those concerns. That is the sort of research and analysis which the agency has taken into account in devising the current scheme.

Senator DEAN SMITH: That leads nicely to my first question. Why was a three-month period chosen and not, for example, a six-month period in regard to the opt-out?

Mr Kelsey: The opt-out trials tested two months. In that report, that was deemed to be too short. Three months was felt to be the right length of time for the level of communication that is necessary.

Senator DEAN SMITH: On that basis, six months could have been suitable as well. So why did we choose three months? Two months was identified as being too short.

Mr Kelsey: As I understand it, there was consultation with clinical leaders and so on. There is, as I said, a clinical urgency in realising an acceleration of clinical benefits. If three months, from the evidence we had, was regarded as a proper length of time for this conversation, that would mean there would be three months more of clinical benefits being realised for people who are otherwise potentially at risk of adverse drug events or other situations in health care.

Senator DEAN SMITH: Finally, I want to go to the difference between default access settings and advanced access settings. An e-health record gets established, and my understanding was that there were some default access arrangements and then there are the advanced access arrangements. How is the consumer aware that there are the default and advanced access arrangements? My understanding is that the advanced access arrangements give the consumer more control over their record. How are they being made aware of that element of privacy?

Ms McMahon: The advanced access controls you mention are the ones I described earlier: the record access control, the ability to mask certain documents and the ability to see the full history of all access. Those are the controls I described earlier.

Senator DEAN SMITH: They're the advanced controls?

Ms McMahon: Yes, what you're referring to as advanced controls we would consider to be that range of settings that a consumer can apply.

Senator DEAN SMITH: This is my point: the consumer has to consciously apply those advance settings. Is that correct?

Ms McMahon: That's right. If I, as a consumer, in My Health Record, wanted to be notified when a new healthcare organisation was accessing my record or my child's record, I would need to put in my mobile phone number or my email address and express whether I wanted a text message or an email, for example. That's one of the controls. I would need to go into the My Health Record and put those settings in place. So, a consumer needs to do that.

To the second part of your question on how we're raising the awareness of consumers about the availability of these controls and then how to use them—that's through our broader consumer communications campaign that Mr O'Connor listed earlier. We've got a range of direct communications to consumers through the healthcare providers and through a number of other community organisations, which he listed. We can provide the full list of those to you now, verbally, or on notice.

Senator DEAN SMITH: It might have been my misunderstanding. I thought the community awareness program was around the opt-out option, which is available for three months. I'm more interested in making sure that consumers are aware that they can have an advanced setting over their record and that, by doing nothing, they have the default setting.

Ms McMahon: Our consumer campaign is broader than just advising that people can opt out. It's raising awareness about the existence of the My Health Record and what it does. That's the starting point. It's also about their rights to opt out and the time frames in which they can do that. It's about their ability at any point later to cancel their record. And it's about the options they have around managing their own privacy and controlling their record. It has a number of layers. And, through the various stakeholders who are pushing out those messages and assisting us with that, we're attempting to get the messages out to consumers on all of those key points.

Mr Kelsey: The research conducted both during the opt-out period and subsequently confirmed that the public wanted to be communicated with about the following: Firstly, what is a My Health Record? Secondly, what are the benefits of the system and what are my rights to control who sees it? Thirdly, how can I opt out? And fourthly, where can I go for more information? That has been the basis on which we have constructed current communications, which are already active obviously, and looked at the design of the communications program during the course of the opt-out period and beyond.

CHAIR: I think that's it on program 1.2. No further questions? In that case, with the sincere thanks of the committee for a very interesting session, we will release the Australian Digital Health Agency and those officers from program 1.2 who are not required for later parts of the program. We've already released 1.3 and 1.4, so we shall move on to program 1.5, international policy.

Senator WATT: I've just got a few questions about the department's response to the latest Ebola outbreak in the Democratic Republic of Congo. You're the man, Professor Murphy?

Prof. Murphy: Yes. I've just been in Geneva at the World Health Assembly, speaking to the WHO director of emergency response, so I'm well aware of what's been happening.

Senator WATT: I'm hoping to get through this section in about five minutes, so can you very briefly tell us what the department is doing to monitor the new outbreak.

Prof. Murphy: We're in close consultation with the WHO, which is, through its emergency response arm, leading a very effective rapid response. They've got a hundred people on site in the Democratic Republic of Congo. They're currently implementing a ring vaccination program to protect further spread. They believe that this particular outbreak is very likely to be under control. The only concern is the city where there were a couple of cases just last week, but they feel it's coming under control.

The Australian government has committed $4 million to the response, through the Department of Foreign Affairs and Trade. That information was made available to the WHO last week. In terms of risk to Australians, there is very minimal risk—almost no risk. WHO has recommended exit screening of people leaving the Democratic Republic of Congo but that there is no value in entry screening, particularly as it's a very remote country which would be several plane trips away and the number of the cases is small. Our response has been to support the international aid effort led through the WHO, who are hopeful that this will be brought under control fairly quickly.

Senator WATT: Do we know anything about the number of Australians who go to or from the Congo each year?

Prof. Murphy: I don't know the exact number, but foreign affairs are fairly confident that there are no Australians in that area, obviously other than WHO staff—many of whom are Australians—who are working in the response under appropriate controls.

Senator WATT: Has the government sought any advice from you or the department more generally on this latest Ebola outbreak?

Prof. Murphy: Absolutely—the health protection department in the Department of Health has briefed the government throughout the last few weeks on information gained from WHO. We've had a watching brief. We've stood up a small group in the department to monitor this issue, and they're liaising closely with foreign affairs to keep an eye on it.

Senator WATT: What was the branch?

Prof. Murphy: It's the health protection branch in our department.

Senator WATT: Was the advice that's been provided requested by government or was it provided unsolicited?

Prof. Murphy: I think we stood that up. I wasn't here at the time. I'd have to seek advice from my deputy, who was in charge at the time. But I believe that it was requested by government.

Senator WATT: Is she or he here?

Prof. Murphy: Not till the next outcome.

Senator WATT: Okay. Could you check that out for me. In terms of action taken by the government to address this latest outbreak—$4 million in funding to the WHO?

Prof. Murphy: Correct.

Senator WATT: You mentioned Australians who work for the WHO who've been sent.

Prof. Murphy: The director of the WHO's emergency response, Peter Salama, is an Australian. He went out there immediately with the director-general of the WHO, Dr Tedros. The WHO is very sensitive about responses to Ebola, having felt that their response last time

was slow, and they've responded very promptly and very aggressively. He went out there on the ground and inspected the situation.

Senator WATT: Leaving aside those Australians who are part of the WHO contingent, who are now in Africa, have any other Australians been dispatched from Australia—departmental employees?

Prof. Murphy: No.

Senator WATT: So, in terms of Australians, it's just WHO personnel?

Prof. Murphy: The only personnel responding—that's correct.

Senator WATT: I'm not sure if this has come across your desk yet, but the shadow health minister and the shadow foreign affairs minister have written to Minister Hunt and Minister Bishop about this outbreak—the letter was dated 18 May—essentially committing a bipartisan approach here.

Prof. Murphy: Correct.

Senator WATT: Do you know whether anything has been done in response to that letter?

Prof. Murphy: I have seen that letter, and I have seen a response to that letter. I'm not sure whether that response has been sent. But there are responses being prepared by the department for the ministers.

Senator WATT: Is there anything the government is intending to do to take up that offer of bipartisanship?

Prof. Murphy: I think that's a question for the ministers, but there is really nothing more that government can do at the moment. This is well managed by the WHO. We've provided financial assistance, which is what they wanted. But we would certainly be happy, under the direction of the ministers, to further brief other members of parliament. But that's a decision for the ministers to make.

Senator WATT: Do you know anything about that, Minister?

Senator McKenzie: I can take it on notice.

Senator WATT: Has the $4 million that's been provided been publicly announced?

Prof. Murphy: I believe it has been publicly announced.

Ms Beauchamp: It was announced at the WHA meeting last week.

Senator WATT: Has there been a press release from a minister over here about it?

Ms Beauchamp: I'm sure there would have been a press release from Minister Bishop, but I'd have to—

Senator WATT: Okay, we'll have a look. That's it from us for 1.5.

CHAIR: Just quickly on 1.5, Professor Murphy, the Zika outbreak, which I guess came to prominence during the Olympics last year, seems to have faded, at least in the media. Is it still a concern?

Prof. Murphy: Zika is not as much of a concern as it was. The activity has reduced, but it is still there in some countries. There is not nearly as much activity in the spread of the virus as there was when that concern was on in Brazil, but there are still some areas of the world

that have transmission of Zika virus. It's something we're keeping a watching brief on, but it's not posing any significant risk to us at the moment.

CHAIR: For example, it appeared—I don't think it was there previously—in relatively near neighbours of ours. Singapore, I think, had a small outbreak.

Prof. Murphy: Yes. We are connected to a very sensitive international surveillance system that is, again, run through the WHO. We all contribute epidemiology information, so, if any increase in activity was seen, we'd know about it very quickly.

Senator SINGH: To follow up from Senator Watt, is the $4 million that you said has been allocated for this Ebola outbreak coming out of the Health portfolio?

Prof. Murphy: No, it's coming from the foreign affairs portfolio. International health assistance comes from foreign affairs. That's how it's provided.

Senator SINGH: Thank you very much.

CHAIR: If there are any officers from program 1.5 who are not required later, we can release them, which means we are moving onto outcome 2, beginning with program 2.1: Mental health.

Senator O'NEILL: The first questions that I have go to the extension of the suicide prevention trial sites. I asked a number of questions about this matter at the last estimates. Following the last estimates, the department confirmed that a number of members and senators had written to the Minister for Health, encouraging him to consider extending the national suicide prevention trial. The department also confirmed that it was not aware of any PHNs writing to the Minister for Health regarding the extension of the national suicide prevention trial. If this has changed in recent times, could you please advise which PHNs did write to the minister or the department?

Ms Edwards: We're not aware of any subsequent correspondence from PHNs, but we can check that and come back to you if there has been any such contact since we last met.

Senator O'NEILL: Are you sure about that?

Ms Edwards: I'm sure that I'm not aware of any. I said I'll go and check to see if there's contact of which I'm not aware.

Senator O'NEILL: The letters that you received from us indicated a request for a 12-month extension. Are you aware of that?

Ms Edwards: Yes.

Senator O'NEILL: How did you present that information to the minister? Did you present that information or did the minister give it to you? What happened with that?

Ms Cole: Letters that are received in the minister's office are often passed on to the department for advice and/or drafting of a response. Those letters that we're referring to in the QONs are letters which went through that process, and that's why we're aware of them. Those are the relevant letters you were talking about from MPs and senators.

Senator O'NEILL: And you remain not aware of any PHNs having written to the Minister for Health.

Ms Cole: I do not recall any PHNs writing directly to the Minister for Health on this issue. However, we will go back and check all the correspondence records for you.

Ms Beauchamp: It's probably important to say though that, even if there are those letters, the government made significant announcements in the budget on suicide prevention and the trials, funding up to 25 primary health networks to roll out beyondblue's The Way Back Support Service.

Senator O'NEILL: I will get to questions on details about that, but I want to follow this line of questioning now. I'm trying to find out a little bit of detail on this. If the department or the minister has not received any advice from the experts—which, in this case, we're calling the PHNs—that they wanted any extension, how was the department able to advise the minister on his recent announcement that an extension was needed?

Ms Cole: Although the PHNs did not write to the minister, which was your question, we're aware that many of the community groups who were involved with the suicide prevention trials were indicating that they would like to see an extension. In addition, given how long it was taking to get services up and running in some of those sites, there was some basic thought that the evaluation period was not going to be long enough for us to come to a meaningful conclusion about the success or otherwise of those trials. Those things in combination were part of the thinking behind the advice that was provided to the minister.

Senator O'NEILL: Does it concern you, Ms Cole, that the information you've received came from community groups? It either wasn't give to the PHNs or the PHNs thought it was of insufficient import that they didn't bother to advise the department or the minister.

Ms Cole: The PHNs are involved in those community groups as well. You asked me quite directly: did any PHNs write to the minister on this issue? My advice to you was: I'm not aware of any PHNs writing directly.

Senator O'NEILL: I gave you a chance to correct the record this afternoon. You could have easily said, 'No, but community groups that are associated with the PHNs did,' but you continued to say, 'No, there's been no advice.' Pardon me, but I'm looking for fulsome answers to the questions that the community has asked me to be put you.

Senator McKenzie: Chair, I think the officer has been answering Senator O'Neill's question.

Senator O'NEILL: Senator McKenzie, you're not the chair anymore.

Senator McKenzie: I understand that but, as minister, I'm able to approach the chair and suggest that we give the officers a chance. You asked quite a direct question about whether anyone had written. They answered it and, following further questions, they've fleshed that out for you.

Senator O'NEILL: And now I'm critiquing the response from them.

CHAIR: Your job is not to critique the response; your job is to ask questions, Senator O'Neill.

Senator McKenzie: Thank you, Chair.

Senator O'NEILL: I want the truth in answer to those questions, Chair. I don't want some word game. I asked: did you receive information from the PHNs? In your answer, Ms Cole, when you clarified, you said that community groups that are associated with the PHNs have been in touch with you. Surely that's close enough for you to have said something about the PHNs.

Ms Edwards: I had understood that you were following up on—you simply referred to correspondence. We are not aware of any correspondence. We undertook to go and check that, which we will. Of course officers in Ms Cole's division are speaking to community groups, PHNs and all sorts of people involved in the suicide prevention trials and are monitoring them closely all the time. In the course of that work, they gathered information from PHNs, from community groups, from the basis of our own material and from published literature, which gave us a suggestion that an extension would be warranted, and advice was provided by the minister. The minister then made a decision to extend the trials.

Senator O'NEILL: And there were six letters from Labor members of parliament.

Ms Edwards: No doubt letters to the minister would have also been taken into account by him on their receipt.

Senator O'NEILL: I want to get it on the record that I want full answers here, not half answers. Can the department clarify what advice or what processes it provided to the minister so he could make this decision?

Ms Edwards: The Minister is briefed. We provide advice to the minister on a range of issues, updates and decisions. One of the issues on which we provided advice was on the question of the duration of the trial. The minister decided to extend the trial.

Senator O'NEILL: What was the basis of you giving him that advice? What research did you undertake?

Ms Edwards: I think I just indicated that we based our advice on interactions with the PHNs and community groups, on our understanding of the progress of the trials from our own records and on academic literature.

Senator O'NEILL: Were all of these just phone conversations? Did you receive anything in writing at all?

Ms Beauchamp: My understanding is, last year—it was before I started—a number of organisations, particularly mental health organisations, met to identify cross-sector gaps in mental health services where their collective expertise, skills and knowledge would have the greatest impact. I think suicide prevention was identified as one of the most urgent priorities after the department and the government had received advice from a number of mental health organisations.

Senator O'NEILL: What date did you indicate that was?

Ms Beauchamp: I think it was across a number of states and key organisations. I'd have to find the exact details, but my advice is that that occurred sometime in 2017.

Senator O'NEILL: A letter from the minister states, 'Changes to the scope and length of the trial will be considered in consultation with PHNs and the evaluation steering committee.' Can the department detail when consultations started with the PHNs and the evaluation committee, and who this consultation was with? Indeed, who's on the evaluation committee?

Ms Cole: We'll take on notice the members of the evaluation committee for you.

Senator O'NEILL: Is that because you don't know them or because you don't want to disclose them?

Ms Cole: I don't have them listed on my papers right now. I'll take that on notice. The evaluation committee hasn't been going that long, as the evaluator was only chosen in November or December. It would have been some time around that period.

Senator O'NEILL: So the evaluator was chosen in November last year?

Ms Cole: I'll check that date for you. We've got it somewhere in our things. We went through an ATM process and a relevant university was chosen.

Senator O'NEILL: Ms Beauchamp, in the interim could you clarify the intersection of what you described as consultations during 2017 that led to this extension by the minister and the evaluation committee and its processes? Are they parallel; are they integrated; did one precede the other?

Ms Cole: Sorry, Senator. I just need to correct my previous evidence. It was actually February this year that the tender for the evaluation process was completed. Sorry, what was your second question?

Senator O'NEILL: If I can go back to Ms Beauchamp, if the evaluation committee evaluator, the person who leads that committee, I'm assuming—is that correct?

Ms Cole: The evaluation is being done by the University of Melbourne. It has an advisory committee to help it with the technical and policy issues surrounding the trials and the evaluation. We'll get you those members on notice, as I mentioned earlier.

Senator O'NEILL: When you say evaluator, you mean the institute that won the tender—not a single individual?

Ms Cole: Yes, that's what I mean.

Senator O'NEILL: So that came in February 2018. That goes to the question I was asking Ms Beauchamp. You indicated that conversations or evaluations throughout the course of 2017 led to this announcement.

Ms Beauchamp: I'd have to take on notice all the details of those consultations that did occur and get back to you.

Senator O'NEILL: To be clear: can the department detail when consultations started with the PHNs around—

Ms Beauchamp: I'm not talking about just PHNs. I'm talking about a number of relevant organisations.

Senator O'NEILL: If you can separate them out for me, I'm particularly interested in your consultations with the PHNs, when they occurred, where they occurred and who was present.

Ms Cole: We talk to PHNs all the time about a variety of issues. I and the relevant officer who is responsible for the PHN programs and the mental health programs, the four of us, are in contact with those PHNs almost daily, so your request could be difficult to answer, from that point of view.

Ms Edwards: Perhaps we could outline key events or documented meetings or so on that come up in our records and also give you a flavour of the regular contact that happens between officers and PHNs on a day-to-day basis.

CHAIR: Could I just jump in there to clarify. The design and evaluation of the trials is not the role of the PHNs?

Ms Cole: That's correct.

CHAIR: The PHNs are effectively the service delivery agents on the ground?

Ms Cole: That's correct.

CHAIR: So can you clarify who was doing the design and evaluation?

Ms Cole: The design of the evaluation was done by the department in conjunction with various experts to make sure that we got the tender correct. Then the evaluation itself, which is being done by the University of Melbourne, has an advisory committee to assist it in terms of any questions or technical issues that might come up during the evaluation; for example, how we're going to get some data to be able to show before and after the trials themselves—that kind of thing. The PHNs, as you correctly attribute them, are actually the service deliverers. They're the ones handling the funding on the ground. They're also doing the infrastructure underneath the trials, in terms of setting up community advisory groups and working with them to determine what steps will be taken at each location and, similarly, what will be funded at each location for each of the trials.

Senator O'NEILL: Can I go back to the minister's letter, which says, 'Changes to the scope and length of the trial will be considered in consultation with PHNs and the evaluation steering committee.' Can you detail when these changes to the scope and length of the trial were considered in consultation with the PHNs and the evaluation steering committee?

Ms Cole: In relation to the evaluation steering committee, I'll come back to you with dates on notice. In terms of the PHNs, we have a constant conversation with them. One of those conversations is often, for example, the length of various programs, what they're up to, that sort of thing. In those conversations, some of the PHNs have mentioned that they think it would be beneficial to have an extension of the trials. To document that is going to be very difficult, because they are casual conversations that we have PHNs all the time.

Senator SIEWERT: That letter implies a much more formal process. Taking on board what you've said about that to and fro, which I understand, did you have a formal process of going to the PHNs and consulting around this specific issue?

Ms Cole: No, we did not, because we already knew what their views were.

Senator O'NEILL: So when the Minister wrote this, 'The trial will be considered in consultation with the PHNs and the evaluation steer committee', as Senator Siewert has indicated, that creates an impression of a formalised process. With the short period of time from February estimates to now can the department explain how comprehensive these consultations were with the PHNs and the evaluation committee, given there was an additional $13 million allocated to the trials? I would hate to think it was just on the basis of conversations.

Ms Edwards: There may not have been a formal consultation process in the way you might have expected.

Senator O'NEILL: From the Minister's letter.

Ms Edwards: Engagement with the PHNs actually entails a genuine and rich consultation, day to day, a true relationship between us, an engagement where officers know each other

very well and discuss issues up to daily throughout the teams that I lead. That is actually a very effective way of making sure we understand their views, including on this issue. It may not fit into the design you've taken away from the letter, but consultation it was and is. We continue to have very rich discussion with the PHNs every day.

Senator O'NEILL: I have a couple of concerns. I agree that this is of sufficient importance—we've been asking for this trial to be extended for a long time now. We understand that it's of sufficient importance, yet the processes don't seem to be very transparent or very careful. There's no correspondence. There are no reports. There are no detailed, written submissions from the PHNs to request this additional funding of this $13 million. Is that correct?

Ms Edwards: It's an ongoing collaboration.

Senator O'NEILL: Does this mean that anything that the PHNs want, they don't need to go through a formal process? They just need to keep talking to you and get what they want when they want it? You can't have it both ways.

Senator McKenzie: That is not what the officer said, Senator O'Neill.

Ms Edwards: I think in my previous answer I made it clear that the views expressed by the PHNs, by other community groups, from our own knowledge in the department and also from academic resources, a broad advice was provided to the minister, and the minister, also having other correspondence to him directly, as you pointed out, made the decision to extend the trials.

Senator O'NEILL: So the minister made the decision?

Ms Edwards: Yes.

Senator O'NEILL: You mentioned academic resources. What were they and who were they from?

Ms Edwards: I'd have to take it on notice. We have a lot of expertise in our teams. They spend a lot of time getting across material. Ms Cole may know more.

Ms Cole: The other thing to take into account is that we fund the Black Dog Institute to support the trials over the period of the trials, in terms of technical advice and academic advice. They were obviously keen to see the trials run for an appropriate period as well.

Senator O'NEILL: Did they provide a written request for an extension to the trials to you?

Ms Cole: I will have to check.

Ms Beauchamp: Could I just add, in terms of providing advice and for the government to make decisions, including the minister, it's not only letters we rely on and advice from other organisations. We actually look at the evidence. When you start having a look at the evidence base around suicide in Australia and the groups most affected and the like, we do draw on research that's commissioned and also research that's available through ABS, AIHW and others on suicide prevalence and the like, in terms of giving our departmental advice to the minister and the government when considering any changes in policy or initiatives.

Senator O'NEILL: Given that you were preparing this advice, can you indicate when you gave this advice to the minister? Did you advise the minister, 'You should extend the trials and you should make it $13 million'?

Ms Edwards: Senator, you would be aware that we don't reveal the content of our advice to the minister.

Senator O'NEILL: Did you provide formal advice to the minister around this?

Ms Edwards: Yes.

Senator O'NEILL: When did you do that?

Ms Beauchamp: We would have done that through the budget process. We're always providing advice to the minister on a range of matters.

Senator O'NEILL: Can we be specific to this matter—the $13 million that was announced in response to the extension requests of the PHNs that were advocated by many Labor members and community groups attached to PHNs?

CHAIR: You don't seem happy about it, Senator O'Neill.

Senator O'NEILL: I'm happy about the quantum. I'm just concerned about some of the processes. When did that evidence that you say you drew on and your recommendation go to the minister as part of the budget process—what date?

Ms Beauchamp: I'd have to take that on notice, but we don't normally provide information in confidence around—

Senator O'NEILL: I'm not asking about the detail. I'm well within my rights to ask what date.

Ms Beauchamp: Let me take that on notice. We're providing the minister with advice all the time, every day. I'd have to go back and single out exactly what pieces of advice were provided and when.

Senator O'NEILL: You said it was as part of the budget process?

Ms Beauchamp: When we're looking at any figures and changes in policy or extensions of funding, that's normally based on advice provided by the department to the ministers.

Senator O'NEILL: When those pieces of advice are funded, they're normally locatable within the budget. Why wasn't the trial site extension announced as part of the budget?

Ms Beauchamp: Why was it announced as part of the Budget?

Senator O'NEILL: It wasn't.

Ms Edwards: It was announced on 14 May.

Senator O'NEILL: What was the catalyst for the minister to announce it after the budget, so that it wasn't announced as part of the budget?

Ms Edwards: There wasn't a specific budget measure in relation to the extension because additional resourcing was found within an existing program.

Senator O'NEILL: Which program?

Ms Cole: The money is found within 2.1, the mental health funding.

Senator O'NEILL: This is mental health funding, $13 million that's come from somewhere else.

Ms Edwards: It's the outcome we're now discussing within that program.

Senator O'NEILL: What was it allocated to before?

Ms Edwards: It was within the money allocated to 2.1. It was available and it was allocated to this priority. The minister announced it on 14 May.

Senator O'NEILL: To be clear, this is not additional money? That's why it wasn't announced as part of the budget. It was already in the budget.

Ms Edwards: It was in the existing program.

Ms Cole: It was within the forward estimates already available.

Senator O'NEILL: So this was not money attached to this year's budget? It was money attached to the previous year's budget?

Ms Edwards: It's not a specific measure in the budget. It's an allocation of money within the current program across the forward estimates.

Senator O'NEILL: I'll come back with a more detailed question on that one. Why did it take the minister so long to make his decision to extend the trial sites, when it had been called on for such a long period of time?

CHAIR: I don't think you need to answer that question.

Senator O'NEILL: Maybe it was because there weren't clear processes about informing his decision. When did the minister make this decision to extend the 12 suicide prevention trial sites?

Ms Edwards: It was announced on 14 May, as I think I indicated.

Senator O'NEILL: Did you give him advice around that period of time or prior?

Senator McKenzie: They've already taken that on notice. They'll get back to you with the date on that. We've been really clear. We seem to be going around in circles.

Senator O'NEILL: Just tell me out here, did you give the minister information? Did the minister decide to extend the 12 suicide prevention trial sites before or after the budget?

Senator McKenzie: It's taken on notice.

Senator O'NEILL: Did you provide your advice before the budget or after the budget?

Ms Edwards: We provided our advice before the announcement.

Senator O'NEILL: Before the announcement but after the budget?

Ms Edwards: We've taken it on notice.

Senator McKENZIE: We have already taken it on notice.

Senator O'NEILL: It doesn't seem to be a particularly difficult question to answer. So could I ask you to see if you could find that out and get that back to me today? The 13 million came as part of the general funding that was in 2.1; is that correct?

Ms Cole: That's correct.

Senator O'NEILL: And the quantum of funds in the 2.1 is how much?

Ms Cole: In the relevant financial year, which is the financial year coming, so 2018-19, the mental health bucket available under 2.1 is around 800 million.

Ms Edwards: 856.4 million I think. Yes.

Ms Cole: 856.4 million.

Senator O'NEILL: 13 million of that now has been allocated to the extension of the trial sites?

Ms Cole: That's correct.

Senator O'NEILL: Thank you. And can the department provide details about how the 13 million will be allocated across those 12 trial sites?

Ms Cole: It's on the same formula as the original funding, which means there's a million dollars for the extra year for each of the sites, and there is also some additional money to extend the evaluation for that extra year and also to extend the support supplied by the Black Dog Institute to the trials.

Senator O'NEILL: How much is for the evaluation and for the Black Dog Institute of that million; is it split evenly?

Ms Cole: So those are currently being negotiated. They will be no more than—I think it's up to $400,000 for the evaluator and up to $600,000 for Black Dog Institute. But I'll just confirm, it may be the other way around for those two.

Senator O'NEILL: Okay, that's fine. But there will be no additional funding to answer the concern about the remote communities who were under the impression that they were going to get additional funding to deal with the geographical reality and the costs of moving across large areas in regional Australia?

Ms Cole: Those costs have been basically met largely by the PHN already in terms of the travel costs for community members and so forth. The answer that we gave you around this very issue in the QONs outlined quite clearly that there had been minimal expenditure on that kind of thing, because it had been found within the PHN's general administrative budget on the whole.

Senator O'NEILL: So the $1 million that's been allocated, or $3 million in each situation with the $1 million additional now, none of that budget is going to operational matters, such as petrol in cars or accommodation? The PHNs are finding that from—

Ms Cole: Generally that's what's happening. There is some minimal expenditure. I'll have to give you a breakdown by each PHN to be able to answer that question more.

Senator O'NEILL: That would be of great interest, frankly, because the burden of that cost in the remote contexts—and I'm mindful of Senator Dodson being here; up in Western Australia it's a very significant issue—and for regional and rural Queensland and in some parts of the north of New South Wales, these concerns about the costs of travel have certainly been well articulated by those communities. You can't confirm that all of the funding is quarantined for on-the-ground services only?

Ms Cole: Some of the funding is not actually quarantined for on-the-ground services in the sense of actual clinical services. Some of the funding is being used, for example, for training of local community members and so forth, in order to help them be able to identify people who may be suicidal or who may need a little assistance. So, for example, quite a few of the sites have indicated that they're going to have or are going to expend money on training community members through things like mental health first aid and some of the other more specific suicide prevention training type programs. And some of the sites have also indicated

that they're doing some specialised training for GPs, for example, to assist them to be able to deal with people in this situation more readily.

Senator O'NEILL: Will you be able to provide a report that indicates, by suicide prevention trial site—maybe like a pie chart, indicating the ways in which the funding that's already been used has been allocated to different parts, and clearly identify where funds have gone to the practicalities of simply moving people around?

Ms Cole: Yes, I can do that for you.

Senator O'NEILL: And a breakdown with the training education, the community education and awareness raising?

Ms Cole: Yes. To get those specific numbers we'll have to go back to each site, so it's not something we'll be able to do today.

Senator O'NEILL: I understand.

Ms Cole: Thank you.

Senator O'NEILL: And service provision clearly is something where people are really interested in finding out how much of this money is going in to create the space that fills those service gaps that were there in the first place.

Ms Cole: Yes.

Senator O'NEILL: When you're doing that, could you indicate for each trial site how much of the funding's been spent to date for each location?

Ms Cole: Yes, we can do that too.

Senator O'NEILL: Great. And can you say generally if they're roughly keeping on track with their spend?

Ms Cole: Most of the trial sites have taken quite a while to get their community organisations or their community working groups working well and at a stage where they're able to actually endorse decisions. So most of them are behind in terms of expenditure.

Senator O'NEILL: So we've got a pretty significant time lag.

Ms Cole: Yes.

Senator O'NEILL: How do you expect that to affect the evaluation?

Ms Cole: I think that, because we've got the extra year, we will actually be fine. I don't think that we will necessarily be able to see a direct correlation between the number of suicides within the sites, but what we may start to see is some community comfort, I guess, around the issues improving. Also, possibly, if we're lucky we'll be able to see something in terms of the self-harm statistics being reported within those areas.

Senator O'NEILL: Thank you.

CHAIR: I've got a few questions on the suicide prevention trial sites, and I suspect Senator Siewert may have as well. Am I correct in saying that part of the structure of the program is that we've got the trial sites to try and generate a varying range of approaches and through the evaluation process we're trying to work out what works best in certain contexts—that's part of the process we're undergoing here?

Ms Cole: That's exactly right. It's not only the geographical differences between the sites but also the target groups. The suicide prevention sites were asked to concentrate on the four very high risk groups. One of those is, for example, veterans, and the Townsville site is primarily focusing on veterans as a result. Similarly, we've got our two Aboriginal sites, in Darwin and the Kimberley, and there we're trying to work out what works best in the city situation versus the remote situation in terms of the best sort of methodologies, I guess, or the best tools that work in those situations, given how different they are, while they're still looking at a target population with a very high suicide rate in both of those communities. Some of the other rural ones are looking at farmers, which has its own set of particular problems in terms of communication with those individuals and so on.

CHAIR: And part of the evaluation process is going to be comparing like with like, so we're going to compare—

Ms Cole: Yes, where we can.

CHAIR: regional areas in Western Australia with regional areas in New South Wales?

Ms Cole: That's right. The idea is that, for example, if something works well in the Kimberley, it may well work in the Cape York region as well, where you've got a similar population. It doesn't necessarily mean that the sites will directly compare one to one with each other but more that we've got enough different situations to be able to apply successful interventions into similar geographical areas with similar problems.

CHAIR: Are different trial sites at very different stages of work? What's the variation between the most advanced and, I guess, the one that's still working up?

Ms Cole: The two that I'm most familiar with, for example, are the Kimberley and Darwin, and I would say that Kimberley is considerably more advanced than Darwin. Part of the reason for that is that it has been much easier within the Kimberley to identify the community leaders to talk to and the number of communities to focus on. Darwin has been much harder because, while you do have the local people, the Larrakia people, you also have a number of transient populations in and out who you also want to target, and actually getting a handle on that group and consulting with it has proved to be quite difficult.

CHAIR: I guess it's the PHNs and through them to you. Are you getting feedback from local communities? How are the individual programs, the individual sites, being embraced by local communities?

Ms Cole: I think most of them were concerned about how slow it was at the beginning, but, now that they're seeing services and education and so forth rolled out, they're starting to embrace it. The Townsville one is a good example of that. There was a lot of concern around how long it took to actually get it up and moving. But I understand that that veterans community generally within the Townsville region is very supportive of the trial now that they're starting to see things on the ground.

CHAIR: Can you just talk me through—and if this is a different topic, I'll go to Senator Siewert rather than talk about it here—the Million Minds Mission. Does that tie in to these trial sites, or is that completely separate?

Ms Cole: That's separate in the sense that that's an MRFF.

CHAIR: In that case, I'll ask about it later. We'll go to Senator Siewert.

Senator SIEWERT: I have a few questions around a couple of the smaller programs, before I move on to the bigger programs. In the budget there's the funding for the Junction Clubhouse, Head to Health, and Lifeline for crises, although that's a bigger allocation of funding, and then the prioritising of mental health. I'm not commenting on the value of the programs. What I'm asking is: how is the decision-making made around some of those program allocations? Are they tender rounds? How is the decision made to pick out those programs for funding?

Ms Edwards: There's a combination of ways it comes to the attention of the government. We have pre-budget submissions and so on from organisations. We have a lot of intelligence that we have gathered in the context of the mental health program. Obviously, it's a very large program, as you know. We're doing lots of various things. Sometimes the department is aware of where there might be gaps or ways whereby we can get really good, effective value for money on large or small programs to extend and so on. Obviously, the minister is also meeting with stakeholders, and they will be passing on views to him. There wasn't an open round to do with this particular injection into the mental health arena, but we are at a place where we spend $4.2 billion a year on mental health. We're looking across that suite of measures to see where there are additional things that we can apply money to to either fill gaps or respond to particular emerging demands. So it's in response to those types of factors that this package is put together.

Senator SIEWERT: How do you do the evaluation? Again, I'm not passing any comment on the value of these programs. How do you look at what you've funded already? There's some ongoing evaluation, but how do you know that these are the best value for money programs in terms of producing the outcome? I don't mean just value for money but producing the outcome.

Ms Edwards: It's a complex process. If you look at something like suicide prevention, there is a large suite of activity that was already underway, and what was announced in the current budget was some additional elements to augment areas. That makes the evaluation across the whole suite complex, but, of course, it wouldn't be appropriate to wait and see if we can see ways to actually help now. For example, the extension to Lifeline is something where we will say: 'Right. We know that's the front door in for lots of people in distress.' Yes, it makes it more complex, but, as always, when you are dealing with real, live human beings, we don't want to wait and see. We want to step in where we can and then devise more complex evaluation processes to see how we're going and try and disaggregate.

Senator SIEWERT: For the programs that you've funded in this round, will there be an evaluation process beyond whoever puts in their next pre-budget submission?

Ms Edwards: There's a mixture. Some programs, particularly the larger ones, have evaluation inherent within them. Ms Cole may be able to help me on the specifics.

Ms Cole: I might go back to Head to Health, which you mentioned. Head to Health is a little bit different, because it was developed in response to the Mental Health Commission's recommendations back in 2014. With Head to Health, we were able to find spare money to set that up, but to be able to maintain it long term we needed a budget initiative. It's got two years, because we're going to evaluate it towards the end of that period and consider at that point whether it's done its purpose, which was essentially to act as a front door to direct people to the right digital service.

Junction Clubhouse was the other one. Junction Clubhouse has been funded from the department since about 2013, I believe. It's very similar to many of the other programs we fund under Day to Day Living. In fact, actually it's provided by some Day to Day Living providers in Queensland, but in the Cairns region. Because it hasn't been formally in the Day to Day Living program stream, it didn't fall under the same extensions that we gave them all until 2019. So essentially what we're doing is just extending that and bringing it in line. What other programs did you mention?

Senator SIEWERT: SANE Australia's program.

Ms Cole: So SANE is one year funding only, with a trial of that campaign with an evaluation.

Senator SIEWERT: The evaluation is already built into the process?

Ms Cole: That's correct.

Senator SIEWERT: I want to go to a couple of the other funding programs: the after-care following a suicide attempt, the allocation of $37.6 million. From the information in the budget papers, that's to go to the PHNs to run. Is that correct?

Ms Cole: Yes, that's correct. The reason for that is that for the program to be successful requires a partnership, essentially, between the hospitals in the region and the local service providers, and the PHNs, essentially, broker that relationship.

Senator SIEWERT: Can you tell me then what role beyondblue has in terms of the funding that's going then to the PHNs for both components of the program? They're getting $10.5 million to provide national support and oversee the program, and then the rest of the funding presumably is then for the implementation of the program?

Ms Edwards: Yes, it's a three-way partnership. As Ms Cole mentioned, the PHNs are involved in order to make sure we get in with hospitals, but beyondblue have the model and a lot of the control over that. So it's PHNs engaging with beyondblue and with hospitals to make sure that the care is happening after a suicide attempt. Beyondblue is actually contributing some money itself, and we're seeking to leverage state and territory contribution as well, because, as you know, this is a complex across.

Senator SIEWERT: I'm not quite sure what role beyondblue plays out of that?

Ms Cole: So beyondblue doesn't deliver on the ground, but, essentially, they're providing support to the PHNs in terms of making sure that model on the ground has what we call model fidelity, so it actually matches what they've found or trialled to be successful. Beyondblue's also has a role to provide technical advice. Finally, the last part of it is that we're hoping that the states and territories will be involved and including beyondblue helps us to facilitate that kind of partnership.

Senator SIEWERT: It seems like a lot of money: $10.5 million—I presume that $10.5 million is over the four years. Is that correct?

Ms Cole: Yes.

Senator SIEWERT: I'm happy for you to take this on notice, because we all have a lot of questions in this outcome or area. Can you take on notice how that will work? My calculation is that's around a bit over $2.5 million a year for what that support looks like?

Ms Cole: Yes. We'll take that on notice and give you a bit of a breakdown, because those were fairly complicated discussions with beyondblue.

Senator SIEWERT: If you could take that on notice. I heard what you said about state and territories coming on board; I would think, given the nature of this program, they're essential. Have you got them on board already? If they don't get on board, does that mean the state and/or territory misses out?

Ms Cole: So in this particular case, it's not a matched funding requirement. It's seeking co-contributions from the states and territories. Both the Northern Territory and the ACT are already involved in providing these services.

Senator SIEWERT: So, if they don't throw money in the intention is to roll it out across the country?

Ms Cole: To 25 PHNs.

Senator SIEWERT: How many PHNs have we got?

Ms Cole: Thirty-one.

Senator SIEWERT: All right. So, why aren't we doing it for the other—

Ms Cole: Because some of the regions already have this in place.

Senator SIEWERT: They're already providing the service, so other regions that don't are now getting this funding?

Ms Cole: That's correct.

Senator SIEWERT: Are you providing funding to those other six in a separate program?

Ms Cole: We already provide funding to all PHNs for suicide prevention, and some of them have chosen to work with their states and territories to provide aftercare-type services post a suicide attempt.

Senator SIEWERT: Do you not expect them to come back and say, 'Hey, you're giving them extra money'? We've been talking about this aftercare for a long time, so it seems to me that this is an essential funding program, but some have done the right thing and started already, have been forward-thinking or whatever and are already funding this.

Ms Cole: I'm sure there'll be some robust discussions in the future around some of these issues.

Senator SIEWERT: Gee, if I was running one of them I certainly would be. I've got lots of other questions, so I hope I'll get another go, but I did want to go to older Australians' mental health, on page 117—the provision of mental health services in residential aged-care facilities. Can you take us through how that funding is going to be provided? It's not through better access, is my understanding. Can you outline how that funding is then going to be rolled out and how the facility's going to access it?

Ms Edwards: We'll give Ms Cole just a moment's break. It's two measures, as you know. There's $82.25 million to the new mental health services for inside residential care and an additional $20 million for people older than 75 in the community. In the residential care it's going to be done through PHNs so that we can design services that actually meet the needs that are particular—and they might be very different needs—to people with mental health issues in residential aged care. We're just at the beginning of that development, working with

PHNs as to what sorts of services might roll out in their areas to residential aged care. It might be that they differ between regions. We're going to make sure that they're talking to one another, so we're sharing learnings and so on. But we also want to foster innovation and for people to respond to exactly what it is that's happening in residential aged care in their area. I think that will be an important discussion that we're going to kick off very quickly.

Ms Cole: That's correct. We'll have a discussion with both the national mental health stakeholders and the national aged-care stakeholders to set the parameter. And then at a local level the PHNs will be responsible for having a discussion with particular service providers, including the aged-care service providers.

Senator SIEWERT: Specific programs then will enable some early intervention processes, and if people actually need mental health direct support services they can access those as well through this funding?

Ms Cole: Yes. The PHN can provide, in essence, the gamut of care. It might be that in a large nursing home you want to do some group work with counsellors around grief and grief resolution as a kind of preventive measure, but you may also be directly providing psychologist services for individuals who have a more severe condition.

Senator SIEWERT: With all due respect, I get nervous when I hear, 'you may'. Will every resident in an aged-care facility who needs individual counselling or mental health support services through this program be able to access them, wherever they are across Australia?

Ms Cole: I'm not sure that we can guarantee that everybody will get exactly what they need at any one time, as we'd have difficulty doing that with the mental health system per se. For example, if you're in an aged-care facility in Derby you may not get as timely care as you would in Perth.

Senator SIEWERT: I appreciate your point, if there's not, say, a psychologist in town or whatever. Previously we've been talking about why people couldn't access Better Access, where you can get individualised support. I understand that the government's gone down this route. But, under that program, if for example you'd gone with that program, people could have been able to access those individual supports. What I heard you saying is that, depending on what the PHN decides—

Ms Cole: No, it's needs based.

Senator SIEWERT: Okay. So the PHN does not have a choice. If somebody needs some of those individual support services, they will be able to access those?

Ms Cole: The idea is that the services provided by the PHN for the general public will become available to those in nursing homes on a basis of need, in residential care. They're constructing basically a step-care model based on need, and that will become available in the residential care. So there are some significant advantages to that. For a start, Better Access is very provider driven in terms of access to services, as you know. So what we want to do is essentially load the rural and remote PHNs again to help them get around that problem. The other advantage is that you can offer that range of services and a range of service providers according to the needs of individual residents within a facility. That's the logic, I guess, in a sense. So, if you take your analogy further, under Better Access, you can only access up to 10 individual services. There is no cap on a PHN service.

CHAIR: Is that a natural break point for you, Senator?

Senator SIEWERT: I wanted to ask about mental health nurses and then that's a natural break. So then, for the other part of the program, that's also funding that will go to PHNs?

Ms Beauchamp: Community based?

Senator SIEWERT: Community based.

Ms Beauchamp: It won't go to the PHNs.

Senator SIEWERT: So how's that going to operate?

Ms Beauchamp: I think we're looking at the Australian College of Mental Health Nurses and initially conducting a trial on the rollout of those community based services.

Senator SIEWERT: With the funding that's been made available, they'll operate on a trial basis?

Ms Beauchamp: Yes.

Ms Cole: Yes. So they've got two years to do a trial, because we're not sure entirely what the best approach is going to be in this area. What we're trying to address are the issues around isolation, loneliness and mental health. And then, after that, in years 3 and 4, there's further funding already provisioned once we actually know what the model should be.

Senator SIEWERT: Okay. Presumably, you're working closely with them for a pilot?

Ms Cole: Yes.

Ms Beauchamp: To commence in January 2019. So we're working closely with them.

Senator SIEWERT: So next estimates we'll be able to ask you questions about progress on the development of that pilot?

Ms Edwards: Yes, you will.

Ms Beauchamp: One month after they start.

Senator SIEWERT: Yes, but by then you'll have worked out—

Ms Cole: The shape.

Senator SIEWERT: With all due respect, I do understand what you're saying, but the point I'm making is I want an understanding then of the model that you've worked out. I appreciate it's probably a bit early for me to be asking those questions now, but I do want to be able to find out more once that's developed.

Ms Edwards: We'll welcome your questions at any time, Senator.

Senator SIEWERT: Thank you.

Senator DODSON: I'm interested in the nexus between the social determinants of health and the programs in the sphere of suicide prevention. Given that there's a debate, as you know, on remote housing going on and the reduction of funding to that, the impact of these social determinants is somewhat critical to this. So do you have a discussion, a dialogue, around that?

Ms Edwards: You're talking in particular in relation to Aboriginal and Torres Strait Islander people, Senator?

Senator DODSON: Yes, I am, particularly in Broome, or the Kimberley would be even better.

Ms Edwards: Can I first say that I'm at a bit of a disadvantage because all of my Indigenous Health team are not here today, because they were here last Friday. But we can answer the questions to some extent and take on notice questions what we can't answer. Of course, the social determinants of health, whether it's mental health or any type of health issue for the whole population and for Aboriginal and Torres Strait Islander people, are a key thing. For the Indigenous-specific suicide prevention trials in the Kimberley and in Darwin, it's really at large for those groups to talk about what it is they need to think about in order to reduce suicide rates there. That would include a range of potential issues as well as service delivery.

As the Department of Health, we jealously guard our health related money to make sure we're actually delivering all the clinical services and health related services that we can, but we interact closely with the state and territory governments and with other parts of the Commonwealth in the suicide prevention space, generally, to try to make sure we leverage as much as we can and factor those things in. We do it in mental health and we do it in the full range of primary care that we roll out for Aboriginal and Torres Strait Islander people. You would be aware that there's a long discussion going on at the moment, very much aligned with the Closing the Gap Refresh about the social determinants of health. That was something that came out of the health plan, and there was a big consultation late last year and a report that was released by Minister Wyatt late last year. We're continuing that discussion in relation to mental health and broadly.

Senator DODSON: I got the impression from my last attendance at the Broome suicide forum that there was a bit of a tendency for people to remain siloed in their approaches to the central objective, if I can put it that way. Is there evidence that this is breaking down and there's some commonality towards an agreed plan and strategy that's taking place?

Ms Edwards: Siloed policy in program areas has long been a problem for governments of all types across all sorts of policy areas, including this one. It's certainly something that we are committed to breaking down and working across. Siloed approaches don't work. It's hard to do. It's hard for government to do, but also, often, organisations who've been doing great work in a small area for a long time find it hard to look across. It's something that we bring together across disciplinary-type forums to try to do. Is there evidence that it's working? I hope we're making inroads into this sort of attempt. We're certainly going to keep at it and would welcome input from you or anyone else about how to do it better. But it's a long road and a difficult thing to do. Government is designed in silos, and we have to work hard with our colleagues to break across them.

CHAIR: Before we go to Senator O'Neill—it might be better to go to Senator O'Neill after the break—Senator Steele-John has to be elsewhere after the break, and we are as flexible as we can be in this committee. He has just three questions on health workforce. Do we have officers in the room who could just quickly see if they can answer those questions or, if not, take them on notice?

Senator STEELE-JOHN: Thank you very much. How many licensed medical professionals are registered with AHPRA?

CHAIR: Senator Steele-John has indicated if you need to take this on notice you may.

Senator McKenzie: We might have found the right table.

Mr Hallinan: In 2016, there were 106,634 total registered medical practitioners.

Senator STEELE-JOHN: Are there updated figures for 2017 or 2018?

Mr Hallinan: No, we don't have those figures yet. We get the data on this through the health workforce survey that is completed as part of medical registration processes through the Medical Board of Australia. The next update to that will be in the next six months or thereabouts.

Senator STEELE-JOHN: Of that number, can you tell me how many identified as having a disability?

Mr Hallinan: I'm afraid we don't collect that information, or that information isn't collected through the data workforce survey, so we don't have data on that.

Senator STEELE-JOHN: So you can't even take it on notice, then?

Mr Hallinan: I can seek through the Medical Board whether they do have any source of information for that, but the advice I have at this stage is that it's not information that they've collected through the survey.

Senator STEELE-JOHN: Is there any other time at which we gather information on that area, or is that it?

Mr Hallinan: Not that I'm aware of. It's usually information that's collected by employers. As a department, we don't employ the medical practitioners and we don't have a management role with the Medical Board either. But I'll take it on notice and will see what we can find.

Senator STEELE-JOHN: Fantastic. Would you also be able to tell me if you record information so that we could obtain a gender breakdown? Surely you do that.

Mr Hallinan: Yes, we will have a gender breakdown. I'll just have to find it.

Senator McKenzie: One of the keynote speakers at the rural doctors conference in Creswick earlier this year, Dr Eeman, is specifically focused on this issue. He might be someone, if this is an area—

Senator STEELE-JOHN: Yes. I'm working with group called Doctors with Disabilities. These figures are available in the United States. They collect the relevant data. I'm just trying to ascertain the percentage of our overall medical practitioners who identify as having a lived experience with disability. It's two per cent in the US, so I'm trying to get an idea.

Mr Hallinan: Senator, I do have the percentage of female practitioners. It was 40.7 per cent in 2016.

Senator STEELE-JOHN: All right. So you don't have a tick box, or a whatever, for disability or any other identities or types?

Mr Hallinan: No. The advice that I have is that there is no question asked in the workforce survey on disability.

Senator STEELE-JOHN: Could I ask you to consider that and maybe include it in the one you are undertaking in six months time?

Mr Hallinan: Yes, we can certainly raise that with the Medical Board, but they are an independent agency. They're not an organisation associated with the department and it's not a survey that the department administers or runs. But it's certainly something that I can take up with them.

Senator STEELE-JOHN: Thank you very much. That's much appreciated.

CHAIR: On that note, we will, I think, go early. You may have the call after the break.

Senator O'NEILL: I've just got one question to clean up the last part. Then I'll have more when we come back.

CHAIR: That's fine.

Senator O'NEILL: I was thinking about the question that I asked with regard to the minister making the announcement—

CHAIR: I think we're back to mental health.

Senator O'NEILL: Yes, about the extension to the trial sites. That was made shortly after the budget.

Ms Beauchamp: The 14th—yes.

Senator O'NEILL: Was that based on advice from the department? Why did this not come out as a budget announcement but it was announced a week later? Can you shed any light on that?

Ms Cole: It wasn't a budget decision. It would be unusual to include it as part of the budget announcements, as a result.

Senator O'NEILL: When I come back, I'll have questions about the whole quantum that was allocated in the budget. A whole lot of bits are in it like this and they are just going to be randomly announced, I assume.

Senator McKenzie: No. I think the department's being quite clear. It wasn't part of the budget. It was a decision made by the minister.

Ms Edwards: The budget measures that appear in Budget Paper No. 2, the part of the budget in relation to mental health, add up to the $338 million, but there is also the $800-odd million a year already in the forward estimates and decisions are made on a rolling basis about allocation of funds from those and they're announced from time to time.

Senator O'NEILL: From the $856 million?

Ms Edwards: I think it was $865 million. But it's the money we were talking about before. It's an existing program, which is already in the forward estimates, and decisions are made, as they are in all programs from time to time, by ministers, and this was one of those. It was made around the time of the budget. It was announced on 14 May. We've taken on notice when the advice was provided in relation to the potential extension.

Senator O'NEILL: So when you said, Ms Beauchamp, that you gave advice to the minister around this as part of the budget process—

Ms Beauchamp: I think I said I'd take it on notice in terms of when we provide the specific advice about the use of funds, and I was speaking in a broader context about the use of funding more broadly in budget processes.

Senator O'NEILL: Not this particular program?

Ms Beauchamp: I think the officers said it was from within the existing mental health program and it would have been from uncommitted funds. But, still, we would have given advice to the minister about the use of those funds—yes.

Senator O'NEILL: Thank you.

Proceedings suspended from 16:15 to 16:30

CHAIR: We will continue with program 2.1, mental health.

Ms Beauchamp: Before we continue: I have specific advice in terms of when we provided specific advice around the suicide prevention trials. It was provided to the minister, specifically on this issue, on 6 March this year.

Senator O'NEILL: Which is quite a while ago.

Ms Beauchamp: Yes.

Senator O'NEILL: And certainly not very long after the evaluation committee was established?

Ms Beauchamp: That's right.

Senator O'NEILL: So, the data that you used to deliver that information on 6 March would primarily have been from phone conversations with PHNs and from correspondence received from Labor senators and members?

Ms Cole: And our own advice and the advice of the Black Dog Institute. I will check whether we ever got anything in writing.

Senator O'NEILL: If you could trawl for anything that you did get in writing from any of those agencies, I'd appreciate that. Thank you for getting back to me. How much money was allocated to mental health in the 2018-19 budget?

Ms Edwards: Are you talking about new measures or overall?

Senator O'NEILL: Give me overall and new measures.

Ms Edwards: So, you're after 2018-19?

Senator O'NEILL: Yes.

Ms Edwards: In 2018-19, the mental health program is $856.4 million. The additional budget measures are $338.1 million. I don't know if I have 2018-19. There are large amounts of money allocated to both MBS mental health related services in 2017-18. That was $1.2 billion. PBS prescriptions for mental health related illnesses was about $500 million. This is in addition to, obviously, our share of hospital funding for mental health services. And there is also research. The total annual approximate expenditure by the Australian government on mental health is $4.2 billion—

Senator O'NEILL: Before you go to that, hospitals and research—you've given me the names; can you give me the breakdown?

Ms Edwards: In terms of research split between the NHMRC and the National Mental Health Commission, there was $79 million. This is for 2017-18. It takes a total in 2017-18 of $4.275 billion. In relation to 2018-19, which was your question, I haven't got that whole wrap-up number, but the mental health program is $856.4 million. It's in addition—am I right?—to the $338.1 million budget measures.

Ms Cole: No.

Ms Edwards: That includes it?

Ms Cole: Yes. That will include that year's worth of those.

Senator O'NEILL: Could you clarify what you were saying then?

Ms Edwards: It's $856.4 million in 2018-19 for mental health programs through the Department of Health. That includes that year's allocation of the new budget measures, which were announced this year in the budget.

Senator O'NEILL: It includes the $330 million?

Ms Edwards: It includes the portion of that $338.1 million, which is attributable to that year.

Senator O'NEILL: Which is how much?

Ms Edwards: $43.2 million.

Senator O'NEILL: How much was allocated in the 2017-18 forward estimates for the 2018-19 year? Is this an increase of $338.1 million in mental health funding?

Ms Beauchamp: That's a figure over the forward estimates and beyond, because of the research component, which goes longer than the forward estimates.

Senator O'NEILL: Can you sense what I'm looking for? A clear and concise breakdown.

Ms Cole: The budget measures for mental health, which make up the $338 million that we're referring to, largely stretch from 2017-18, because there were a few things which were funded this financial year to 2021-22, the end of the forward estimates. However, there is a big component, which is 2022-23 to 2026-27, that is to do with mental health research, the Million Minds mission.

Senator O'NEILL: How much is that?

Ms Cole: That component is $62.5 million for that period.

Senator O'NEILL: For 2022-27 or in two separate amounts?

Ms Cole: From 2022-27. The total value of Million Minds is $125 million over the 10 years. It's 12.5 million provided annually. I actually led my boss astray—

Ms Edwards: I was happily right the first time! The $856.4 million is before the budget measures for 2018-19. To that, you need to add $43.2 million, which are the new budget measures attributable to 2018-19, which gives you a total of about $900 million.

Senator O'NEILL: Can the department provide the total amount of funding for mental health services in the 2017-18 budget as a total, and what was allocated for each year over the forward estimates?

Ms Edwards: 2017-18? Last year's budget? It's in the budget papers.

Ms Cole: It is in the budget papers. I don't have the year-by-year breakdown with me, but I can probably get it for you over the course—

Senator O'NEILL: You can take that on notice.

Ms Edwards: It would have been in last year's budget papers. We've obviously updated.

Senator O'NEILL: Can you do that for this year in the same way?

Ms Cole: I think we've just gone through that, but we can go through it again if you'd like.

Senator O'NEILL: If you can put the two years next to one another for comparison, that would be really good. Has the department allocated any amount of funding to mental health past the forward estimates? Any of that $33.1 million?

Ms Edwards: Yes. In relation to the research proponent, the Million Minds Mental Health Research Mission is a 10-year mission. That goes beyond the forwards.

Senator O'NEILL: To 2022-23 and 2026-27?

Ms Edwards: It goes to 2026-27.

Senator O'NEILL: And that's a total of $125 million?

Ms Edwards: That's correct.

Senator O'NEILL: How much will be spent, and in which year will you expect that money to be spent or allocated?

Ms Edwards: For Million Minds?

Senator O'NEILL: Yes, the additional funds.

Ms Edwards: It's allocated as $12.5 million per annum starting in 2017-18.

Senator O'NEILL: Of the additional $43.2 million for this year, what's the allocation breakdown for that?

Ms Edwards: This is for 2018-19. For improved access to psychological services for older Australians in residential care there's $7.8 million. For mental health nurses supporting Australians over 75 years there's $0.8 million. For strengthening the National Mental Health Commission there's $3.2 million. For after-care following a suicide attempt there's $6.5 million. For Lifeline Australia for enhanced telephone crisis service there's $6.1 million. For funding for Head to Health there's $2.1 million. For funding for the Junction Clubhouse there's $0.3 million. For the suicide prevention campaign there's $1.2 million. For the Million Minds Mental Health Research Mission there's $12.5 million. For mental health outreach through the Royal Flying Doctor Service there's $2.8 million.

Senator O'NEILL: And the total of that?

Ms Edwards: $43.2 million.

Senator O'NEILL: Do we have the same breakdown in the forward estimates for the following year?

Ms Edwards: Yes.

Senator O'NEILL: The same projects?

Ms Edwards: Yes.

Senator O'NEILL: How much are we talking there?

Ms Edwards: One is a zero number, but we will get to that. This for 2019-20. For improved access there's $16.5 million. For mental health nurses there's $1.1 million. For the National Mental Health Commission there's $3 million. For suicide after-care there's $8.5 million. For Lifeline there's $6.1 million. For Head to Health there's $2.7 million. For the Junction Clubhouse there's $300,000. The suicide prevention campaign is one year only, so that's a zero figure. For the Million Minds Mental Health Research Mission there's $12.5 million. For mental health services through the Royal Flying Doctor Service there's $5.8 million. That's a total of $56.4 million.

Senator O'NEILL: For 2020-21?

Ms Edwards: For improved access there's $26.4 million. For mental health nurses there's $8.9 million. For the Mental Health Commission there's $3 million. For suicide after-care there's $10.6 million and for Lifeline there's $6.1 million. There's no allocation for Head to Health. It's two-year funding has been provided. There's no funding for the Junction Clubhouse and none for the suicide prevention campaign, which was for one year only. There's $12.5 for Million Minds mission and $5.8 million for the Royal Flying Doctor Service. That's a total of $73.4 million.

Senator O'NEILL: And the last one?

Ms Edwards: For the 2021-22 financial year there's $31.7 million for improved access. For mental health nurses there's $9.2 million. For the National Mental Health Commission there's $3.2 million. For suicide after-care there's $12.1 million. For Lifeline there's $15.5 million. That is a much higher number in that year because core funding that we had previously provided expires, so it reproduces the core funding plus the additional. There's no funding for Head to Health, the Junction Clubhouse or the suicide prevention campaign. There's $12.5 million for the Million Minds Mental Health Research Mission and $5.94 million for the Royal Flying Doctor Service. That's a total of $90.1 million.

Senator O'NEILL: Thank you. Could I just ask a couple of questions around the Million Minds project?

Ms Edwards: Yes, although, because it is an MRFF project, my staff may have to take some of those on notice because the MRFF staff have returned to the department. But we will do what we can.

Senator O'NEILL: The budget indicates $125 million provided over 10 years, and you have just indicated that that's $12.5 million each year over that period. In the minister's own words:

Million Minds will be looking at a range of areas including eating disorders, suicide prevention, Aboriginal and Torres Strait Islander people's mental health, depression, anxiety, bipolar disorder, and other areas of critical importance to national mental health and wellbeing.

That was said at the University of Melbourne 2018 Dean's Lecture on 16 May. Please indicate how much money will go to each of these areas of mental health research. The first one was eating disorders.

Ms Beauchamp: It is probably a bit early to do that because, as part of that initiative, the mission was going to be guided by a research road map. The research road map was going to be developed in consultation with researchers, clinicians, consumers and co-funders. But it was also looking at the umbrella of the fifth mental health and suicide prevention plan, consistent with the Australian Medical Research and Innovation Strategy 2016-2021. So, whilst all those areas have been identified, the actual disbursement and the money to be allocated will depend on the development of this road map.

Senator O'NEILL: People in the sector are already banking on these commitments having been delivered, and they're pretty keen to find out how much they've got. I think they would be pretty disappointed that there is no clear policy at this point in time. What is the research road map? You said it 'was' to be guided? Is it still to be guided?

Ms Edwards: Yes, it is.

Senator O'NEILL: And there is the umbrella of the fifth mental health plan. What is the funding timeline for the release of the first $12.5 million, and how will these very important sectors of the mental health tapestry engage in securing funding?

Ms Edwards: As an MRFF program, it will follow the process we were discussing this morning. Dr Hartland might be able to help us out. The priorities are set by the priorities for that program, and then the program is developed in consultation with experts and so on and there will be a competitive element to make sure we get the best projects for the money available. Dr Hartland, did you want to comment?

Dr Hartland: Sorry, Senator; I was out of the room when this was raised.

Senator O'NEILL: Are there priorities among the priorities? Is there any direction that's been set yet? Is it possible that bipolar disorder might not get anything in the road map until the 10th year? Is that possible?

Ms Edwards: I couldn't comment at all on what will be in the road map.

Senator McKenzie: That's a hypothetical. I think it's unfair to the officials to take guesses at what may or may not happen over the next 10 years.

Senator O'NEILL: I think it's nowhere near as unfair as it is to the sector, who have no idea about when this money's coming through or who might get it.

Ms Beauchamp: I think there's a commitment. It's talking about new research, and there's a commitment to work with and consult with researchers and clinicians and the like, so in a sense it's developed in collaboration with all those people that are relevant.

Senator O'NEILL: Dr Hartland?

Dr Hartland: To reiterate what Ms Evans and the secretary were saying, the government's recently announced the MRFF commitment. We're going through a process of consultation to work with the sector to develop up the research. I think that, if the government had just put flat on the table the precise areas and conditions that it wanted to research, we'd have another problem, which would be lack of consultation. With all of these MRFF programs, there's a commitment to make sure that we engage properly with the sector and to work through what the most productive research questions to pose are, and that's where we are with the mental health.

Senator O'NEILL: There are likely to be priorities among the priorities. If I read this list, are these in any particular order: eating disorders, suicide protection, Aboriginal and Torres Strait Islander people's mental health, depression, anxiety, bipolar disorder and other areas of critical importance to the national mental health and wellbeing? They're not in alphabetical order. Is there any order amongst that? Are there priorities amongst the priorities?

Ms Edwards: I think we'll be taking advice from researchers and other experts on how the road map should fit together. That's the purpose of developing the road map: to see which and in what order and how. Some of these things may be dealt with together; some separately; some sooner and some later, depending on the quality of the research and what the sector say. It's certainly not for us to set those priorities in advance of those processes.

Senator O'NEILL: So it is possible that suicide prevention might have no further funding for many years?

Ms Edwards: We'd expect the road map to deal with all of the priorities that have been identified and sort them and allocate them as is best to get the best level of research.

Senator O'NEILL: Or eating disorders could be waiting for many years before they actually get to a priority level for the road map?

Ms Beauchamp: This is only one element of mental health funding that Ms Edwards spoke about. This is funding under the MRFF, which is really focused on translation research. It will be looking at helping and assisting patients, particularly around new research, diagnosis and treatment. I think it will depend on what the clinicians and researchers say but also perhaps the readiness of some of that research to be applied over the next 10 years. It's a good time frame in which to do it, but this is only one area of mental health funding that's looking at those sorts of issues.

Of course there's other program funding. There's NHMRC funding that's applied to mental health as well, so that also needs to be taken into account. That's looking at—I think Ms Edwards said it was—$79 million worth of research applied in 2017-18 under other programs outside the Million Minds.

CHAIR: With all due respect, Senator O'Neill, you are verging on the seriously hypothetical here.

Senator O'NEILL: I don't think it's hypothetical that, of the research money that's going into the NHMRC, there's a very, very small proportion going to mental health and an even smaller proportion of that going to things like eating disorders and anxiety, which are affecting our young people. I'm interested for people to find out.

CHAIR: That wasn't the burden of the question you asked before, but please continue.

Senator O'NEILL: What will the process be? What will the consultation look like? I'm hoping it won't be like the consultation around the PHNs and the suicide prevention extension.

Ms Cole: The minister had a roundtable in Parliament House a couple of months ago, on 5 March, in which he had a number of very prominent researchers in this area. Also the NHMRC attended, as did the department, largely as the support function. From that, an initial draft road map was developed by the department. It was presented to the minister for consideration.

The minister then consulted with four prominent professors in this area to refine it a bit more because he felt it needed a little refinement before it is sent out to the wider group of stakeholders, researchers primarily and also the major mental health stakeholders, for a further consultation on the roundtable. He's also indicated that he will have an advisory group. He's indicated four members. I'll just turn to my colleague to tell you who those are.

Ms Wood: As Ms Cole says, the minister's yet to establish the advisory panel and confirm its role, but that will be associated with the road map that's going to go out, we expect, this week for consultation. The four members are Professor Helen Milroy, Professor Shitij Kapur, Professor Patrick McGorry and Professor Tracey Wade.

Ms Cole: Those are the four members that are currently known and identified by the minister.

Senator O'NEILL: They will be the only members of the advisory group?

Ms Cole: No, I expect it will be wider than that, but those are the members he announced recently at his presentation to the University of Melbourne.

Senator O'NEILL: How many others have you recommended should be on the advisory group?

Ms Wood: We haven't yet got that far. The minister has a number of people whose involvement in the panel he's interested in our exploring, but he's yet to establish the panel and its terms of reference and the number of advisers that would be part of that panel.

Senator O'NEILL: Are you able to advise the details of the attendees at the roundtable that was held on 5 March?

Ms Cole: Yes. We'll take that on notice.

Senator O'NEILL: Thank you very much.

Ms Cole: It was about 25 different individuals.

Senator O'NEILL: Is the initial road map available?

Ms Cole: It will be available around the end of this week.

Senator O'NEILL: The four prominent professors that you referred to at that point—are they the four that have been named?

Ms Cole: Yes.

Senator O'NEILL: On what date was it that the initial road map went to the minister?

Ms Cole: We might have to take that on notice because I can't remember off the top of my head.

Senator O'NEILL: Thank you. Could you give a list of the researchers and stakeholders that you're consulting with.

Ms Cole: Yes.

Senator O'NEILL: Thank you. Could I go to the Mental Health in Education initiative. You answered a question on notice for me, SQ18000330, where I was asking about how much money has been allocated to the evaluation of the national education initiative. Based on your answers, I've got a series of questions.

Ms Cole: We'll just find that question.

Senator O'NEILL: Senator Dodson has a question that's related to the Million Minds, I think.

CHAIR: Sorry, go ahead.

Senator DODSON: How do you set your priorities within the First Nations domain when it comes to health or the dimensions of health that you cover here?

Ms Edwards: In relation to mental health?

Senator DODSON: Mental health and any sort of health that you do—whatever funding you provide to whomever to do something.

Ms Edwards: Again, Senator, I'm home alone on this one, as my Indigenous team are not here, but let me at least provide a broad answer. Firstly, we have the $3.9 billion over the forward estimates which is the Australian Indigenous health program. About half of that fund is primary care through the Aboriginal-controlled health sector, and then the balance of the

funding goes to a range of things: eye health and ear health, which were featured in this budget, and programs to tackle smoking. There is also a significant amount of funding which is provided for mental health programs for Aboriginal and Torres Strait Islander people. That's provided through the primary health networks, although quite a lot of that funding then reverts back to the Aboriginal-controlled network to provide services.

That's the core Indigenous-specific health funding, but that is not the sole priority for Aboriginal health initiatives through the Australian government, let alone through all governments. Obviously, one of the key things we need to do is make sure that the MBS and the PBS, the mainstream programs, are appropriately targeted to fund services for Aboriginal and Torres Strait Islander people. Also, in our hospital funding, we make sure that the way we fund states for hospital services takes account of the needs of Aboriginal and Torres Strait Islander people. In addition to that, we work with states and territories, who obviously have a big role in this field. Across all of that, which is the health funding across the whole of the Australian governments, we then try to link that back in with Aboriginal and Torres Strait Islander affairs and spending generally to make sure that we actually hook in—as we were talking about before—where there are social and cultural determinants of health, so that the other areas of government programs align, because obviously, in an isolated way, health programs are not going to be sufficient to really close the gap on life expectancy or any of the other key measures. All of those priorities were initially set, obviously, by COAG, and then we have complicated processes by which underlying priorities are set, both across the whole of government and then within the health program, both across the whole of the department and within the Indigenous health program. The priorities there are, of course, making sure we have effective primary care and that we tackle chronic disease, and maternal and child health is another key priority. Those are set by government but very much in consultation with the sector, with the community and across all of governments.

Senator DODSON: Can you tell me how many First Nations people you've got employed in the department?

Ms Edwards: About 2.7 per cent, I'm told. Our corporate people may still be here to tell us the exact numbers. In fact, the secretary probably has the number here.

Senator DODSON: Maybe you could give that to me on notice. Coming back to the research stuff, what role, if any, does the Lowitja Institute play in providing advice, guidance and direction, or even undertaking research?

Ms Edwards: The Lowitja foundation is a premier institution for whom we have enormous regard and value. It's currently funded by the department until, from memory—again, I haven't got my full team here on this stuff—June 2019, and we're currently considering funding options into the future. It conducts research and also provides invaluable advice, and we treat it as a very valued and important stakeholder and contributor.

Ms Beauchamp: Of those that are self-identified as Aboriginal or Torres Strait Islander workforce in the department, as at 30 April we have 2.9 per cent.

Senator DODSON: What's the number? I don't know what your total workforce is, so I can't work out the number.

Ms Beauchamp: Oh, sorry. It's 2.9 per cent—I'll have to work it out myself—of around 4,400.

Senator McKenzie: A lot.

Senator DODSON: The minister says it's a lot, so I presume that's a lot!

Senator McKenzie: I can do the maths: 2.9 per cent on 4,000. I'll do that while you keep talking.

Senator DODSON: Okay. I can do that as well, but I haven't got a calculator.

CHAIR: Just before we move on, I did have some questions about the Million Minds Mission, most of which you've answered. But, just to be clear, it's basically a research-driven project; it's not about delivering services on the ground. It's about doing the basic research.

Ms Edwards: It's about research but also about translational research. It's a collaboration between the mental health part of the department and the MRFF teams, and it does fit into that idea of: let's find the causes and treatments and so on for particular mental health disorders and how we actually best put that into practice. So it's not about providing clinical services, but it's about researching the whole pathway to make sure that we can get from great ideas that our Australian researchers might have, find them out and put them through the entire pipeline to actually then deliver on-the-ground treatment and services. But it doesn't fund those treatments and services—that's at the other end.

CHAIR: Just to be clear, what input are you having to the project—the Million Minds Mission?

Ms Edwards: It's funded from the MRFF.

CHAIR: Yes, I got that.

Ms Edwards: And the mental health teams will be working on preparing the beginning of that road map. Then the MRFF will have regard in terms of its priorities and so on as well, the two things will come together and the funding will flow to researchers.

CHAIR: Great, thank you. I just wanted to clarify that.

Ms Beauchamp: Just to respond to senators in terms of numbers in the department, it's around 125.

Senator DODSON: So 125 out of 4,000?

Senator McKenzie: It was 4,282.

Senator O'NEILL: Could I just ask: why is the Mental Health in Education initiative an 'opt in'? Why isn't it mandatory, because we know that mental health issues are happening in every educational site across the country?

Ms Cole: Senator, that's to do with a constitutional issue around the states and territories controlling education. We're not able to dictate to them that they use a particular program or whatever. But this program is well respected. It's based on Minds Matter and KidsMatter, which have been in a large major of schools across Australia for some time. So we're not anticipating that we'll have some issues around acceptability of the new, revised program.

Senator O'NEILL: What work are you doing to ensure as many schools as possible participate?

Ms Cole: So beyondblue have indicated they believe they'll be able to double the number of schools participating over the period. I'll just turn to my colleague in terms of the actual numbers that they're indicating.

Ms Wood: They're aiming to reach about 6,000 schools nationally in the first year of the program, which is expected to commence in August this year.

Senator O'NEILL: Is the department confident that this can be achieved?

Ms Cole: We're pretty confident because of a couple of reasons. One is that beyondblue were already running those programs before they were revised and vitalised and they already had a fairly good reach into schools at that point. The other reason is that they have done a huge amount of work, consulting with the state education departments and the schools themselves in order to make sure there is a high acceptability of the new program.

Senator O'NEILL: How similar to or different is it from the Minds Matter and KidsMatter programs, which had pretty amazing coverage across the country?

Ms Cole: Essentially, KidsMatter and Minds Matter and then some work that was done around early childhood were all developed at slightly different times. KidsMatter had been around for 15 years or something like that—we can check that for you—and Minds Matter was a later version developed by a different organisation. We've asked beyondblue to make sure that the program is cohesive from the early childhood right through to the end of high school. It's taking the basic principle of those two programs, which was essentially around assisting teachers to teach basic resilience and other skills—emotional intelligence type skills—as a preventative measure as well as being able to identify at all those different stages, depending on what type of teacher you are, children who may require some additional assistance or showing sciences of perhaps trauma within the family, early signs of mental health, suicidal ideation and all those sorts of things. So it is taking those ideas and ensuring that there's a consistent thread and theme right from the three- and four-year-olds right up to the 18-year-olds.

Senator O'NEILL: How much effort has gone into making sure that the whole school context is part of the framework, because it is not just about information and skilling up; it's about school context?

Ms Cole: Particularly for the high school age children, basically from 12-year-olds and above, there is also a component which is around school support, which is specifically around suicide attempts and suicides within a school community and responding quickly and appropriately to that. Another part of the program is around creating linkages between local appropriate services and the schools, so that the schools are able to refer appropriately to headspace or whatever might be appropriate.

Senator O'NEILL: I will come to some detailed questions about that. Which states and territories are you expecting these services to be delivered in?

Ms Cole: All states and territories.

Senator O'NEILL: Everybody's participating?

Ms Cole: Yes.

Senator O'NEILL: The evaluation that you described doesn't focus on outcomes. Is there a reason for that?

Ms Cole: The one that we've described in the—

Senator O'NEILL: In your QON response.

Ms Wood: We spoke about the two individual evaluations—the one being undertaken for the workforce initiative that supports this, and the education initiative that's being run by beyondblue. They're about design and implementation of those individuals. We're also undertaking an overarching evaluation of the combined that Ms Cole just spoke of. We've just gone out to market for that and we're engaging an evaluator to undertake that evaluation, and that will look at outcomes.

Senator O'NEILL: Outcomes for?

Ms Cole: The whole preventative child support programs—the two major programs that we run.

Senator O'NEILL: Do you have any details about that? If it's gone out to tender I'd say it's reasonably advanced. Would you be able to provide the plan and what you're up to?

Ms Cole: We can provide that.

Senator O'NEILL: Great. In January this year there was an announcement of more funding to beyondblue. Was any of that funding including additional funding for evaluation?

Ms Cole: No, it's service delivery funding on the whole.

Senator O'NEILL: What's the quantum?

Ms Cole: It's up to $23 million per year for an additional two years. However, they are required to do the evaluation as part of the overall grant that they have to run this program, so presumably they'll use a small proportion of that to keep the evaluation running for those extra two years.

Senator O'NEILL: So what's happening with the evaluation if all the money is going to services? Where's the funding for the evaluation?

Ms Cole: I just explained that. We haven't actually contracted this amount with them yet; we are still in discussions with them. The evaluation was part of the overall initial proposal from beyondblue when we went and approached the market. We're expecting that they will continue that evaluation as appropriate over those additional years, but we haven't finalised our grant condition discussions with beyondblue yet.

CHAIR: So they're delivering the program and part of the delivery of the program includes evaluation?

Ms Cole: That's correct.

Senator O'NEILL: And they have been funded already for that?

Ms Cole: Yes.

Senator O'NEILL: To what amount as part of that? Is that specified?

Ms Cole: They have allocated just over $550,000 for the evaluation to date.

Senator O'NEILL: Over what period of time?

Ms Cole: This will be for their initial funding agreement, so the first two years. I'm not expecting that it will cost that much to continue it on for the following two years because essentially, once you've got your parameters in place, you kind of wait for things to happen that you are then evaluating.

Senator O'NEILL: And repeat. I want to take this opportunity to shout out to the 35 headspace centres that I visited around the country and congratulate them all on the amazing work that they do. I want to put on the record how concerned I continue to be about inadequate funding and a failure to index and about the impact that that's having on people working in those services and on continuity of care. If the program that we've just been discussing is successful, there will naturally be a significant increase in the number of students who will be referred to services or encouraged to attend services, particularly services like headspace. You indicated I think earlier this evening that part of the money is to create better linkages between schools and health services that exist in the community. My question really is: how is headspace and other local community services, including GPs, going to cope if this program is successful?

Ms Cole: Part of the success of this program is I guess in a sense preventing children from actually getting the more severe or the more moderate forms of mental illness wherever possible, so addressing issues early. I don't know that you can necessarily draw a direct correlation between the success of this program and an increase in the number of people presenting at headspace. However, having said that, we do appreciate the issues you've raised around capital redevelopment for headspace centres and indexation, and that's something we're working on internally at the moment.

Senator O'NEILL: And they're two separate things—capital funding and indexation for ongoing recurrent needs?

Ms Cole: Yes, and we understand very clearly that they are two separate things.

Senator O'NEILL: Have you got any news for me about that?

Ms Cole: No, I don't.

Senator O'NEILL: Is the minister going to make an announcement next week?

Ms Cole: I don't have any news for you on that. It's an internal discussion.

Ms Edwards: We should put on the record that we do spend $273.6 million on headspace service delivery—that was 2016-17 to 2018-19. As Ms Cole says, we continue to work very closely with services and with the national office for headspace. We also monitor very closely and keep abreast of what's going on. We are very committed to the services and making sure they can cater for the demand. We're watching them closely. We have nothing to inform you of at the moment.

Senator O'NEILL: So can you assure me that students who are empowered to acknowledge that they need some assistance with mental health will find the health care that they need?

Ms Cole: We can't guarantee any particular person any particular service but I can—

CHAIR: I don't think that's the officer's job, but the minister may want to comment.

Ms Cole: We definitely have a strong commitment to the services.

Senator McKenzie: Senator, I think asking the officer that type of question is really just being quite free and easy with this process. She's here to answer questions around budget estimates, not to provide guarantees for your press releases.

Senator O'NEILL: Well, I hardly think that this matter of youth mental ill health and suicide—

Senator McKenzie: Oh no, Senator O'Neill, do not underestimate my concern and intent to address mental—

Senator O'NEILL: It's a lot more important than a press release, Minister.

Senator McKenzie: health issues of students across this country, but—

Senator O'NEILL: So are you going to guarantee that if they need to go and get treatment, that they're actually going to—

Senator McKenzie: choosing to play cheap political points through the Senates estimates process—

Senator O'NEILL: You're a teacher; you know what goes on in these classrooms. You know teachers picking up kids in between classes who need to go and get health care, and they can't get it at the moment.

Senator McKenzie: by expecting the officers of the department to play some cheap political game on your part is ridiculous, and it's continuous. And I'm saying enough.

Senator O'NEILL: There is no cheap political game, Minister, in a student needing—

Senator McKenzie: Enough!

Senator O'NEILL: access to services that your government has failed to fund adequately.

CHAIR: Senator O'Neill, this is not a question.

Senator McKenzie: I'm very proud to be part of a government that's making record investments into mental health services across this country and particularly $110 million for young people across this country—

Senator O'NEILL: Chair, Senator McKenzie cast aspersions on my determination to have these questions asked on behalf of young people across the country.

Senator McKenzie: in January which I'm happy to run—

CHAIR: I think it is very unproductive to talk over each other. So let's move on. I have some questions on beyondblue. Is the funding you talked about in response to Senator O'Neill's question, the $40 million over two years, the only funding to beyondblue in the recent budget? Does that include the Way Back Support Service?

Ms Cole: No, this is separate from the Way Back Support Service.

CHAIR: Can I get an understanding of what the Way Back Support Service is and what it's trying to achieve?

Ms Cole: That's the suicide after-care—

Senator SIEWERT: That's the one I asked about.

CHAIR: I am very sorry; I missed that. If this question has been already been asked and answered then I shall move on.

Senator SIEWERT: Well I knew what it was for. I was asking questions about it.

Ms Edwards: We may have jumped over. So the program is directed to that high proportion of people who've had a suicide attempt and end up in hospital. Many of those people have never had any access to mental health services before—it's their first presentation—and this is a measure to try and ensure that there's appropriate follow-up care. It's something that has been rolled out on a smaller scale to date, and the budget decision was

to expand it significantly to work with PHNs, hospitals and beyondblue, to do model fidelity, to make sure that when people come out of hospital after a first suicide attempt—perhaps they've never had any contact—that there's follow-up, because we know that the time that people are at most risk of a successful suicide attempt is immediately after an unsuccessful attempt.

CHAIR: So was this is a national program before or is it—

Ms Edwards: No.

Ms Cole: So beyondblue's after-care program is a little different in that it's actually trying to deal with the social issues that may have encouraged or may have created the situation under which a person felt that they needed to end their life—that they couldn't see a way out. So, for example, if they had a financial crisis, a relationship break-up or similar. What it does is hooks them up with, essentially, a person who can provide that kind of social care and assistance in getting the right services so they can get out of their financial problems or similar, for those three months. An example is domestic violence: there's a strong link between domestic violence situations and suicide. So it's around providing that assistance to smooth over those aspects of their life, which they felt might have meant that they could no longer exist, and to get forward momentum,

That doesn't mean that they don't also need clinical care, and the clinical care is the responsibility of the existing services, whether those are state or whether they are funded by the Commonwealth. You know, for example, seeing a psychologist to deal with depression, anxiety or whatever, which may have contributed. So it's around trying to look at the whole circumstances of an individual and to address those circumstances which drove them at that particular point in time towards a suicide attempt.

CHAIR: It may just be because I haven't been here for an overly long period of time that I hadn't heard of this service. Would it have been operating in Western Australia?

Ms Cole: No, it hasn't been operating in Western Australia. There's been a couple of trials run by beyondblue. One of those was in the ACT, one in the Northern Territory. So those were the initial sites, and then—

CHAIR: So will this funding effectively roll it out nationally? Is that the goal?

Ms Cole: Yes, that's correct.

CHAIR: So they've done the trial. They're now going to roll it out nationally?

Ms Cole: That's right. Some PHNs had already looked at the trial and picked up the service because they thought it was a worthwhile thing to do. And then, essentially, this extends it out to those regions that don't currently have anything similar.

CHAIR: Would this project be tied up in the suicide prevention trials or is it completely—

Ms Cole: It's separate and additional to.

Ms Edwards: Just to give you an indication, I think about 1,200 people have been referred to the service since June 2014. This additional funding will allow support to approximately 28,000 additional people.

CHAIR: You may not be able to answer this, but how does beyondblue go about delivering those sorts of services into rural, regional and remote Australia?

Ms Edwards: Commission specific services that cater for that sort of clientele, working with the local hospital services. Sometimes people from remote or regional areas will have had to have gone to hospital in the city, so there will have to be services that make sure we follow them back home. That's why the PHNs are involved, in order to assess the need and make sure we design and commission services that meet that requirement.

CHAIR: Thank you. Senator Siewert.

Senator SIEWERT: I wanted to go to the issue around continuity of supports. I realise some of this is for you and the rest is for DSS later in the week, but can I ask questions around the bits that belong to you. First off, $92.1 million has been allocated over five years for continuity of supports. Is that right? My understanding is that that is overall for continuity of supports for NDIS.

Ms Edwards: I think that's a DSS budget measure.

Ms Cole: Senator, it is. It's a little complicated. Essentially, there was already funding in the forward estimates for the over 65s for the continuity of support arrangement. This addresses the under 65s. The $92-odd million you're talking about actually covers three programs. Two are ours, which is the day-to-day living and the PIR Program, and the third is the PhaMs program.

Senator SIEWERT: That's one of the things I wanted to clarify. It talks about continuity of supports. Is it just for people with mental illness and psychosocial disability, or is it across other areas as well? I didn't know if you could answer that, so I was going to ask how much has been allocated. Can you tell me how much you've been allocated out of the whole program?

Ms Cole: Our component is the $92 million, I believe, and the remainder of their measure relates to other programs run by DSS. Because it's not our measure, we'll just have to be a little cautious, and you may want to ask about it on Thursday.

Ms Edwards: We're just looking at budget paper No. 2?

Senator SIEWERT: Yes. Is that the extent to which the funding—$29.8, $31 and $30.6 million?

Ms Edwards: Yes.

Ms Cole: Yes. That works out to about the $90 million over the three-year period—90-something.

Senator SIEWERT: That's the issue—it says 'over five years', but from 2017-18.

Ms Edwards: It's only a very small amount in 2018-19.

Ms Cole: Because the continuity of support only applies to people currently in the programs who are not successful.

Senator SIEWERT: I understand that. I'll ask the department about other breakdowns. I want to specifically ask you about the PIR and day-to-day living programs. In terms of the allocation of funding for the programs you have responsibility for, on what basis has it been determined that that is going to be adequate? You've been fairly consistently quoting transition at around 74 per cent. I'm basing this on some PhaMs figures, and I will then ask about day-to-day living and PIR. Based on that, there's nowhere near that level of transition of people moving into NDIS happening.

Ms Edwards: Senator, you will have to follow this up primarily with Social Services later in the week. We work very closely with them, because we want the funding for clients to match the transition, and we're talking to them about that. But all of that projection and working through the numbers and exactly where it's up to—we don't even have particular visibility of exactly who's where in the process, so you really should take it up with them. But I can assure you we're working closely with them to make sure that the funding phasing matches the transition pathway.

Senator SIEWERT: I really don't want to be sent back from them to you, so I'm going to ask you a few more and you can tell me, 'No, go and ask them.'

Ms Edwards: Sure.

Senator SIEWERT: What figures have you provided to DSS to calculate how much funding is needed for continuity of support for Day to Day Living and PIR?

Ms Cole: We use the trial transition rates for our two programs at this stage to work out the continuity of the support requirement.

Senator SIEWERT: So, the ACT?

Ms Cole: Yes.

Senator SIEWERT: Which other trial did you use, sorry?

Ms Cole: And the Hunter-New England.

Senator SIEWERT: Okay. Things have moved on very significantly since then.

Ms Cole: Yes.

Senator SIEWERT: You haven't updated those figures?

Ms Cole: Those are the only ones that we have where we have a full population that's transitioned. That's why we've chosen them. As you know, there is still quite a lot of work to be done, so it's quite difficult to use in-transit populations for those estimations, if you see what I mean. There are many people who've got applications in but have not yet received a full assessment or a plan.

Senator SIEWERT: Yes, I take your point. But, certainly for PHaMs, where I've got the most up-to-date information—because I asked them last estimates—it's nowhere near the 74 per cent transition, and there's more accurate detail there because there are people that have withdrawn their applications or just haven't put any in.

Ms Cole: Senator, you'll have to ask about the PHaMs transition—

Senator SIEWERT: I understand that. I'm using that as an example of where they're up to to basically indicate that those figures are not matching what was originally anticipated and planned for.

Ms Edwards: Senator, I understand your issue and why you're asking us about Partners in Recovery, and Day to Day Living. But, generally, the way the transition works, and the speed of it and how the money matches it, are really matters for DSS, even though their program's transitioning from us. We're working with them with the aim of making sure it is smooth and so on, but they're leading that stuff and have the policy lead. They're no doubt watching, and I'm pretty confident they'll be able to answer your questions and won't send you back to us. That's certainly my hope!

Senator SIEWERT: I'm really trying to get an understanding here. So, you actually don't have line of sight on people transitioning from PIR? You don't actually have line of sight for that?

Ms Edwards: They're definitely the policy lead. They're talking to us about it, but they've got all of that—

Senator SIEWERT: Okay.

Ms Edwards: and they should be able to talk about these programs also.

Senator SIEWERT: Okay.

Ms Edwards: And we'll talk to them in between.

Senator SIEWERT: Are you able to then take it on notice as to how many people are still on PIR—

Ms Edwards: Yes.

Senator SIEWERT: and Day to Day Living that are still receiving funding from those programs? Do you have details on that—either now, if you do, but, if not, can you take it on notice?

Ms Edwards: I don't think we have it here. We can take it on notice.

Senator SIEWERT: Okay. Can I have the most up-to-date figures on how many are still getting funding for Day to Day Living and PIR?

Ms Edwards: Yes.

Ms Cole: Day to Day Living will be tricky because of the nature of the program, but we'll do what we can.

Senator SIEWERT: If you could, that'd be appreciated. Thank you. How much funding is then allocated to that group of people, or will it cost—

Ms Cole: Until full transition, we have the full funding originally allocated for those programs. What the continuity of support is is it's the extra funding required for the under-65s who require funding, whatever—

Senator SIEWERT: Who will require ongoing funding.

Ms Cole: That's right. There's no actual reduction in our allocations, until we go to June 2019.

Senator SIEWERT: Even though some of those people will have transitioned already?

Ms Cole: Yes. There's an in-kind arrangement.

Senator SIEWERT: Yes. That's what I want to know, sorry: do you have the figures for how much now is in-kind contribution?

Ms Cole: To date, the in-kind contribution has been very small. We don't have any figures related to this financial year yet. It's done in arrears as people shift over and then receive services.

Senator SIEWERT: On notice, can you give me whatever figures you've got? That'd be really appreciated. So that's people under 65 who don't transition to NDIS and who need continuity of support who have existing supports.

Ms Cole: Yes.

Senator SIEWERT: I want to go back to the discussion that we had a number of estimates ago and it's been a bit ongoing. What about Those people that would normally have qualified for PIR or day-to-day living, who would normally put in a request or gain support for those programs that don't qualify for NDIS?

Ms Cole: In the future?

Senator SIEWERT: Yes, into the future. There's the $80 million contribution.

Ms Cole: That's correct.

Senator SIEWERT: That's for supporting that group of people. Last time I asked for an update, it was $80 million. Can I ask for an update on that.

Ms Edwards: I think in the last exchange we had on this, I expressed my very keen hope to have it done by these estimates.

Senator SIEWERT: Yes, you definitely did.

Ms Edwards: I did. And I have been making the team work very hard in the interim. So the Western Australian bilateral is signed up and done.

Senator SIEWERT: That's good for my home state.

Ms Edwards: For the other states and territories—

Ms Cole: And South Australia.

Ms Edwards: Oh, and South Australia—hot off the press—is done. In relation to all other states and territories, official discussions are all concluded. We think there are agreements to match funding as content for bilaterals. They have all been approved at the Commonwealth end by the minister, and we're awaiting final approval by state and territory ministers. As far as we are concerned, they are completely done. I had hoped to get more of them back for you today. But we think they're done and they should be emerging very shortly from the other states and territories, and the money will then flow.

Senator SIEWERT: Will there be information available on those agreements? Is that going to be publicly available?

Ms Cole: Yes, they'll be published.

Senator SIEWERT: Once you release them? Will you do them as a job lot or can I go and find WA and South Australia somewhere?

Ms Edwards: I think we'll do them as a job lot.

Senator SIEWERT: In the near future?

Ms Edwards: I expressed my great hope last time and, in the meantime time, we've done everything we can from our end. I've got no reason not to think the other states will quickly finalise it and it will happen very quickly, but we've certainly done everything we can to make it happen really quickly.

Senator SIEWERT: Can I be really cheeky and could you take on notice when they're completed and then make available the agreements?

Ms Edwards: Assuming they're done by the time the date for answers is up, yes.

Senator SIEWERT: That would be appreciated, thank you.

Senator O'NEILL: I have a couple of quick ones. The National Eating Disorders Collaboration's national rollout the workforce capability project, can you give us a quick update on that project and when you expect the rollout to be achieved. I think you were expecting workforce education resources to be disseminated by 30 June. Is that still the date?

Ms Cole: I believe so but I will just ask my colleague. He is nodding.

Senator O'NEILL: Do you want to give me that update on notice or are you able to give me any information tonight?

Ms Cole: My understanding is it's going pretty well. They commenced work on the coordination's identification of gaps in existing workforce education resources. They have done a coordinated suite of existing workforce education resources, which is due to be disseminated by 30 June this year. We have no reason at this stage to believe that that won't happen in that original time frame

Senator O'NEILL: Is it still a trial or has it changed status?

Ms Cole: I don't think this one was every really a trial; it's more like an education project.

Senator O'NEILL: Will each state and territory have access to eating disorder specialists to meet the competencies?

Ms Cole: This is around workforce education—the component you asked about—it's not around service delivery. I mean, it is in the broad, but it's not around creating a new workforce.

Senator O'NEILL: So the issue for rural, regional and remote Australia is access to eating disorder specialists?

Ms Cole: Yes.

Senator O'NEILL: Is there anything being done to that end?

Ms Cole: What this will do is assist GPs and psychologists in those regions to better address eating disorders in terms of services on the ground. For those that are very severe and so forth, there may still need to be referrals into cities, to specialised acute services and so forth.

Senator O'NEILL: So the distribution of the eating disorder specialists really is not being resolved by this—

Ms Cole: No, it's—

Senator McKenzie interjecting—

Ms Cole: That's right. It's a workforce education process, so one of the things that the NEDC were saying is essentially that many psychologists, GPs or whatever, when confronted with a person with an eating disorder or a suspected eating disorder, don't feel that they have adequate skills. So this is around that front line and trying to make sure that that front line of services, whether rural and remote or in the city, is better able to identify those emerging problems and then also better able to initiate early stages of treatment.

Senator O'NEILL: Who's providing that training?

Ms Cole: It's around a workforce resource, and then we'll look at a variety of ways to do it. For rural and remote, we often use our mental health education processes with webinars and local study groups and all those sorts of things, which are run through—

Senator O'NEILL: Has anyone been contracted to do this work?

Ms Cole: Not yet.

Senator O'NEILL: How much is allocated?

Ms Cole: We haven't allocated any additional funding at the moment. We're waiting for the resources to be completed and disseminated, then we'll consider whether we need to do anything—

Senator O'NEILL: What bucket of money will that come out of?

Ms Cole: Most likely out of what's called our national leadership fund, which allows us to do these kinds of one-off projects.

Senator O'NEILL: Typically how much would a program like this cost?

Ms Cole: For a variety of work, we provide them about $1 million a year—it goes up and down a little bit.

Ms Edwards: And that's indicative only, Senator.

Senator O'NEILL: Yes, that's fine. I'm just trying to get an indication. You might remember the voluntary industry code on body image that Labor endorsed in 2010. It seems to have disappeared and I couldn't find it online. It was previously located under the office of youth. Does the department know anything about where that code is?

Ms Cole: No, but we can make inquiries.

Senator O'NEILL: I have a few questions for the Mental Health Commission.

Ms Edwards: Are they questions about the Mental Health Commission or of the Mental Health Commission?

Senator O'NEILL: Probably they are the best placed to respond.

National Mental Health Commission

[17:32]

Senator O'NEILL: In a media release, the NMHC states that the federal government's budget demonstrates 'a commitment to making the mental health of our nation a top priority'. Is the government investing enough on mental health services given the significant increase in demand for services?

Senator McKenzie: I think that's an opinion. Chair?

Senator O'NEILL: Is the quantum of money that you're receiving adequate to meet the service need?

Senator McKenzie: I think the senator is asking for opinions of our officials.

CHAIR: She's changing the question on your recommendation, Minister.

Senator McKenzie: Thank you for accepting my recommendation.

Dr Brown: Sorry, could you repeat your question?

Senator O'NEILL: Is there a gap between the services that need to be provided and the allocation of funding from the government, in your view?

Dr Brown: Again, I'm not here to give opinion about government allocation of funds. There is a significant demand for mental health services across Australia. There is also, I

guess, an argument for investment in promotion, prevention and early intervention. I think the National Mental Health Commission would like to see the investment maximised because we believe that it really is an investment and that you will get return on that investment over time, but we certainly have been pleased to see the priority that this government places on mental health and to see the increased investment that was in this budget.

Senator O'NEILL: Is there a gap remaining between unmet need and service provision?

Dr Brown: The 2014 report that the National Mental Health Commission completed indicated, I think, that there was substantial investment in mental health services across the nation, across both the Australian government and the states and territories. I think it indicated that we were not necessarily maximising the outcome on the returns on that investment. There is a lot to be gained through better organisation of the existing dollars before we necessarily need to start talking about additional investments.

Senator O'NEILL: The next question I have is really going to that sense of is there a plan? Is there a connected strategic plan, or are we seeing in these budget measures another piecemeal approach to mental health? Do you see the strategy in the budget, or is it still lacking that clarity in terms of what the National Mental Health Commission outlined?

Dr Brown: There are a couple of things I would say in response to that. The 2014 report from the National Mental Health Commission put forward a number of recommendations that gave a structure or a framework in terms of continued investment in mental health. We've since then had the Australian government response to that, and we've seen reforms implemented on the ground as a result of that.

We have also seen all health ministers last year endorse the Fifth National Mental Health and Suicide Prevention Plan. Again, that is not necessarily intended to be a comprehensive plan addressing everything across mental health. It was an agreement by all levels of government on eight particular priority areas. So I think we have a couple of existing documents that do guide the investment of governments.

Senator O'NEILL: Was the National Mental Health Commission asked to do any analysis of the measures in the lead-up to the May budget?

Dr Brown: No.

Senator O'NEILL: Why not?

Dr Brown: You would have to ask the government that question, Senator.

Senator O'NEILL: So with a roadmap laying down eight priorities identified, and the capacity of the National Mental Health Commission, why did the government not use that capacity to actually analyse the measures they were proposing in the budget?

Ms Beauchamp: I think we've answered that question in terms of the consultation that was undertaken. But also we did have the Fifth National Mental Health and Suicide Prevention Plan already, which provides that umbrella. One of the measures was looking at the strengthening of the National Mental Health Commission, just to provide that leadership and advice on mental health reforms and also for reporting on the performance of the mental health system across Australia. I think that has been spoken about as not just being a Commonwealth responsibility but a state and territory responsibility as well. I think that the

work going forward, in terms of strengthening the National Mental Health Commission, will provide an updated performance framework for the mental health system across Australia.

Senator O'NEILL: Will the National Mental Health Commission be part of updating that or will its remit the updated?

Ms Beauchamp: The actual measure talks about:

This additional funding will support the Commission to better review and report on the performance of the mental health system in Australia and increase its capacity to provide national leadership in advising on mental health reforms, including expanding its role under the Fifth National Mental Health and Suicide Prevention Plan.

Senator O'NEILL: Were you consulted in a formal way around the extension of the suicide prevention sites?

Dr Brown: No.

Senator O'NEILL: I'm trying to reconcile these two things. You're a really important agency but you are not being consulted about major economic decisions of the government to invest in mental health. There seems to be a gap here between what the minister is doing and the capacity of the National Mental Health Commission to inform the decisions of government with careful analysis.

Dr Brown: I take on board where you're going. I think we need to be mindful that the National Mental Health Commission is a relatively small agency. We do not have the capacity to look at a granular level at each and every measure that government might be investing in. Our remit is to look at the higher-level, broader and overarching approach, not necessarily at specific individual measures.

Senator O'NEILL: Do you think you would have had an instructive contribution to make to a high-level discussion about the extension of the suicide prevention trial sites which you were not asked to consult on?

Dr Brown: Undoubtedly we would have been happy to have made a contribution in discussion with the department, but whether we would have added any additional value over and above the analysis that the department made, I wouldn't necessarily—

Senator O'NEILL: We'll never know, because you weren't asked to the table. Were you consulted on the recent youth funding announcement?

Dr Brown: No.

Senator O'NEILL: How often, then, does the government or the department actually seek advice from the National Mental Health Commission in relation to major mental health announcements and funding decisions?

Dr Brown: Again, we work I guess collaboratively with the department. We don't necessarily expect to be consulted on each particular announcement that the government might be making. But we do seek to work with the sector broadly and with the department in a collaborative way to inform the deliberations.

Senator O'NEILL: What formal arrangement is in place for ongoing consultation with you? Is there any regularity to that?

Dr Brown: We have a regular meeting at officer level.

Senator O'NEILL: How often does that occur?

Dr Brown: Once a month, and we have a periodic meeting with the minister and indeed a twice-yearly meeting with the minister and the Prime Minister.

Senator O'NEILL: Over what period is the periodic meeting with the minister—quarterly? Monthly?

Dr Brown: It approximates quarterly.

CHAIR: Can I just ask a question of clarification at this point, on the role and function of the National Mental Health Commission? My understanding of it is that it's not to advise government on budgetary decisions. Can you just outline your role?

Dr Brown: We have three main functions. The first one is to monitor and report on mental health and suicide prevention systems across the nation. The second is to provide advice to governments and the community on mental health and suicide prevention, and that's a broad advice. And our third function essentially is to act as a catalyst for change to I guess promote mental health reform. So, you're quite right, Senator: we're not specifically set up to provide advice on government budget initiatives.

Senator O'NEILL: In the National Mental Health Commission's view, are the budget measures supportive of the Fifth Mental Health and Suicide Prevention Plan and the National Mental Health Commission's previous recommendations, in whole or in part?

CHAIR: I think we're getting close to asking for an opinion. I'm happy for you to answer that if you see fit, Dr Brown, but—

Dr Brown: I think it's fair to say that in broad terms yes, I think they are supportive of the National Mental Health Commission's previous recommendations and the strategic directions outlined there. And I don't think they're inconsistent with the priorities in the Fifth National Mental Health and Suicide Prevention Plan. Obviously there are specific measures. They're not so broad as to cover all the strategic directions set out in the 2014 report or the eight priorities of the Fifth National Mental Health and Suicide Prevention Plan, but they are certainly not out of alignment with that.

Senator O'NEILL: The title of your work was 'mental health and suicide prevention'. Given that you weren't consulted formally, despite meeting with the minister on a quarterly basis and once—

CHAIR: I think you may be verballing the witness there.

Senator McKenzie: Chair, I'd have to agree with you.

Senator O'NEILL: So, you meet with the officers once a month, you meet with the minister quarterly, and you meet with the minister and the Prime Minister two times a year. Yet, despite that, you were not formally engaged, even though your remit is to advise the government on mental health and suicide prevention, about the extension to the suicide prevention trial site. Is that correct?

Dr Brown: I've indicated that we were not involved in those discussions with the department or the minister around the extension of the suicide prevention trials. We have a broad remit around providing advice, but it doesn't necessarily go to in-depth discussion of every initiative, as I have indicated.

Senator O'NEILL: Without asking for your opinion about whether the government is investing adequately in suicide prevention, what elements of the work outlined by the

National Mental Health Commission remain yet unachieved despite the efforts of the government?

Dr Brown: Are you referring to our recommendations from the 2014 report?

Senator O'NEILL: Yes.

Dr Brown: I think there were nine strategic themes in that report; I can't recall them all of the top of my head. One of the areas we are particularly interested in seeing progression in is early childhood. We have seen the measures around education, and there has been a significant investment there. Aboriginal and Torres Strait Islander mental health is another area where we are keen to see further investment. There has been some investment, but we would be keen to see further investment there. Some of the other recommendations were around, for example, taking the approach down to regions through the PHNs and a more person centred stepped care approach. That is happening with the current reforms. There was a recommendation around research. There's a commitment in the Fifth National Mental Health and Suicide Prevention Plan around the National Mental Health Research Strategy. We have also seen investment in this budget in mental health research through the MRFF. We are seeing a lot of what was set out by the commission in 2014 being progressively implemented.

Senator O'NEILL: Would you like to put on the record any areas of concern?

Dr Brown: Not at this particular point in time.

Senator O'NEILL: How do you view the degree of consultation that you are currently being offered by the government? We know its frequency now, but how substantive is it?

Dr Brown: It's fair to say that the relationship between the commission, the department and the minister's office has been strengthening. The government gave a commitment to strengthen the National Mental Health Commission. We've seen increased investment in the funding available. We've had an increase in the staffing resources made available to the commission. With that we've had increased capacity to engage with the department and with the minister's office. I think we're seeing the benefits of that increased collaboration. I hope it will continue to increase as time goes forward.

Senator O'NEILL: Do you expect to be engaged by the government and the department more regularly around the suicide prevention trials?

Dr Brown: I think we expect to be engaged with the government, the minister's office and the department on a range of issues. That would include suicide prevention measures more broadly.

Senator SIEWERT: What involvement will the commission have in progressing the *National strategic framework for Aboriginal and Torres Strait Islander peoples' mental health and social and emotional wellbeing*?

Dr Brown: We have not been specifically engaged around implementation of the social and emotional wellbeing framework at this point in time. Having said that, one of our priorities in the 2014 report, as I indicated, was around Aboriginal and Torres Strait Islander health, so we are interested in seeing further work in that area. We know that for Aboriginal and Torres Strait Islander people there isn't a clear distinction between social and emotional wellbeing and mental health issues, because of their holistic approach to health. I am co-

chairing the PHN Advisory Panel on Mental Health, of which Dr Mark Wenitong is one of the members. He has been emphasising this issue. That panel is due to report to the minister in the next couple of months, and I expect that there will be some commentary in that report about the need to ensure that there is this unified approach in terms of social and emotional wellbeing and mental health initiatives for Aboriginal and Torres Strait Islander people.

Senator SIEWERT: We ran out of time on Friday. I appreciate you don't have the staff available here, but perhaps I can ask you to take on notice what the department's response is and when we can start to see the allocation of some more resources against the framework.

Ms Edwards: For the social and emotional wellbeing framework?

Senator SIEWERT: Yes.

Ms Edwards: I think that belongs to PM&C these days.

Senator SIEWERT: So I should put that on notice to them?

Ms Edwards: Yes. It used to be mine once.

Senator SIEWERT: I'll put that on notice to them. We were talking about health and things on Friday. I have one other area of questioning.

Senator McKenzie: Is this outcome 5 for Indigenous?

Senator SIEWERT: No, not for my next question. We're still on 2.1.

Senator McKenzie: I'm just saying, because we have received correspondence—

Senator WATT: That might have come from me.

Senator McKenzie: Yes. There are other senators who have questions in the same area. Rather than taking it on notice tonight, it might be better that you're aware of that and you ask them tomorrow.

Senator SIEWERT: Yes. I wasn't going on to that, though—but that's very good advice. However, it's PM&C who I need to ask this one of anyway.

Ms Edwards: In relation to the social and emotional wellbeing framework.

Senator SIEWERT: Exactly. I was just taking a chance, because we didn't get up to that point on Friday.

CHAIR: Can I just clarify, Senator Watt. The request you have tomorrow is purely within outcome 5, isn't it?

Senator WATT: Yes. That's my understanding. I think that's what the letter said.

CHAIR: Great.

Ms Edwards: Senator Watt, could I ask exactly what it is you want to ask about, in order to make sure I don't disturb the day of the wrong people?

Senator WATT: Let me see if I can get some more info on that.

Ms Edwards: If possible. Otherwise I can bring the whole show, but obviously they weren't expecting it.

Senator WATT: I'll get some more info.

Senator SIEWERT: I want to go back to a question I think I asked at the estimates before last—in fact, I'm pretty certain it was then—around the telemental health issue and the face-to-face sessions. You took a question on notice.

Ms Beauchamp: Chair, I'm just going to interrupt. Have we have finished with the Mental Health Commission?

Senator SIEWERT: I beg your pardon, yes.

CHAIR: Let's just clarify it from other senators' points of view: is the National Mental Health Commission required anymore?

Senator WATT: Done. No.

CHAIR: Then you are excused, with our gratitude.

Senator WATT: And, in answer to that question you asked, my understanding is that the questions we have tomorrow for outcome 5 relate to sexually transmitted diseases in Indigenous communities.

Ms Edwards: I have a role in that work through the Office of Health Protection, rather than the Indigenous Health Division. With your leave, Senator Watt, I'll make sure the Office of Health Protection people, who know all about STIs, are here, rather than the Indigenous Health Division.

Senator WATT: That would be great. Are you happy for that to be asked in outcome 5, though?

Ms Beauchamp: Yes, because we'll have the Chief Medical Officer here as well.

Prof. Murphy: We are very happy for that to be asked in outcome 5.

Ms Edwards: Thank you for the clarification. They'll be relieved.

Senator SIEWERT: I want to go back to the issue of the telemental health measure and the face-to-face requirements. You took a question on notice. You provided a response on notice and talked about the efficiency of the program, and we've talked a bit about it before that. I've subsequently received quite a bit of feedback saying that there's little evidence to support the idea that the face-to-face requirements, in respect to telemental health, provide better outcomes. I've been told that people do some of their consultations electronically and then drop out when they don't make the face-to-face requirements. Coming from WA, you can appreciate there are long distances involved for people to come down, so they just don't come down. I have subsequently received evidence—papers—around the value of telemental health. Have you had a look at any of the subsequent work? Can I provide you the papers and ask you to respond to the papers on that? I am deeply concerned that that is a good measure that is being undermined because of the requirement for face-to-face.

Senator McKenzie: Providing the department with your papers and getting a full response would be a really good approach.

Senator SIEWERT: I presume that hasn't changed it.

Ms Edwards: Our response to the question on notice is still our view, but if you provide us some additional material we would be happy to respond.

Senator SIEWERT: I have quite a few references here. Minister, if the papers are to your satisfaction in terms of being clinically sufficient, is there a possibility that the government can change the rules on this program to take out the requirement for face-to-face consultations?

Senator McKenzie: The decision to structure the program as we have was based on sound clinical evidence. If there is clinical evidence that that changes then obviously it is within our remit as a government to review it and have a look at that.

Senator SIEWERT: I will provide you with those references. If you could take that notice, that would be really appreciated.

Ms Edwards: Thanks, Senator.

CHAIR: We have had some negative targeted questions to date, but the increase in $338 million.

Ms Edwards: It is $338.1 million.

CHAIR: That is the increase in spending?

Ms Edwards: That is the increase over the longer period in some instances.

CHAIR: What is the total quantum of spending on mental health over the forward estimates?

Ms Edwards: This requires me to do maths again! It is the number we talked about before. It is $4.2 billion annually. That covers mental health programs, MBS mental health related services, PBS prescriptions for mental health, the Australian government's share of public hospital in relation to to mental health, mental health share of private health insurance rebates and research from the NHMRC and the Mental Health Commission. In relation to the mental health program itself, the one that the team runs, it is over $800 million a year, plus the $338 million. And of my trusty budget people will tell me in a moment what the forward estimates.

Ms Beauchamp: I think we went through the forward estimates with Senator O'Neill.

Ms Edwards: We did—in relation to the addition.

Ms Cole: We did. We don't have is four years with the new budget measures in. What we will do is take that on notice.

CHAIR: Is there even a rough global figure on what the spending is projected to be?

Ms Edwards: It is about $3 billion.

Ms Cole: Over the forwards.

CHAIR: I think everyone acknowledges that there is a lot more to do in this space, including in primary research and the delivery of services. But comparing the current profile of spending to previous profiles, to previous governments, would it be correct to say that there has been a significant step forward?

Ms Edwards: We certainly focused on a very broad range of things—on mainstream services targeting to make sure they cater for mental health issues, on making sure mental health specific funding is targeted to things that really work and also research so we make sure we really investigate the causes of mental health problems and the treatments and how we can best roll them out. So it is evolving into a much broader and more multifaceted program, for which I'm sure everybody is supportive, and there's major investment in this budget.

CHAIR: And the resources that this government has put forward for mental health services are significantly more than in previous years with previous governments?

Ms Edwards: It has been increasing greatly.

Ms Beauchamp: From my observations, having been in the Commonwealth for some time, I think this area was traditionally a responsibility of the states and territories, and I think the Commonwealth government has stepped in, in more recent years, with absolutely record funding specifically for mental health services. What was it?

Ms Edwards: $654 million.

Ms Beauchamp: The $654 million, plus the $338 million, is certainly something additional to what we would normally provide in the mainstream services around MBS and PBS, which is in the order of about $4.2 billion per annum. As you say, there's more work to do, but certainly the Commonwealth government has stepped into a traditional state and territory space in this area.

CHAIR: Thank you very much. With that, we will thank those from program 2.1 who have no further involvement this evening, and we will move to program 2.3, Health workforce.

Ms Cole: Chair, Senator O'Neill, who's just stepped out of the room, asked a question about the meeting date of the evaluation steering committee in relation to the suicide prevention trials.

CHAIR: Yes.

Ms Cole: That committee was established in January 2018. You might remember that the ATM was finished for the actual evaluation in February, but the first meeting of the evaluation steering committee was on 1 February. That was a specific question that Senator O'Neill asked us to follow up.

CHAIR: Okay. We will move on from program 2.1 to program 2.3.

[18:01]

Senator SINGH: I just have a couple of questions in relation to the Murray-Darling medical school. Minister, I wanted to ask you, particularly now that the Murray-Darling medical school network has been announced: will you finally tell us whether it was in the secret coalition agreement?

Senator McKenzie: I'm incredibly proud to be the rural health minister that has seen five end-to-end medical schools and provisions across the Murray-Darling region delivering end-to-end training, as recommended. Senator Siewert, you're probably the only other person in this room that was part of this committee in 2012, when it did an inquiry report that actually recommended exactly this type of training as a way of addressing the maldistribution of doctors in the regions.

Senator SINGH: It wasn't a Dorothy, Minister.

Senator McKenzie: No, I just can't stop talking about it.

Senator SINGH: I was asking whether it was part of the secret coalition agreement.

Senator McKenzie: I'm not going to comment on what is in or isn't in the coalition agreement.

Senator SINGH: Why not? Is it cabinet in confidence?

Senator McKenzie: It's an administrative document. We've played this game at the last estimates. I'm happy to play the same game. We won't get any further down the track.

Senator SINGH: No, I just want your reason. What's your reason? Is it cabinet in confidence? Is it budget in confidence?

Senator McKenzie: The reason we've instigated a policy of end-to-end training in the regions is that it has been part of the National Party policy. It was part of recommendations from this committee.

Senator SINGH: That wasn't the question, Minister.

Senator McKenzie: I think we should all actually be incredibly proud. People go out there and say that this committee's Senate inquiry reports don't deliver anything. Well, now you can all champion that they actually have, as a result of our budget a couple of weeks ago.

Senator SINGH: I'm not getting the answer I was asking for, Chair. I'll throw it back to you.

CHAIR: I think we've been there before, so I think you expected that.

Senator RICE: I want to ask some questions about maternity services. Following the end of the National Maternity Services Plan, which I understand finished in June 2016, almost two years ago, I understand that there's a new process underway with a National Strategic Approach to Maternity Services, and that's currently open for consultation.

Senator McKenzie: We will get the appropriate officer to the table as soon as possible.

Prof. Murphy: I think it is outcome 2.4. I don't think it is outcome 2.3.

Senator McKenzie: This is workforce.

Senator RICE: I was told it was under 2.3.

CHAIR: If it's 2.4, let's do it there, because I do have some workforce questions.

Senator McKenzie: It's just that Senator Rice was advised—

CHAIR: Senator Rice has been incorrectly advised. We will be moving to 2.4 relatively soon by the look of it. Can we just clarify who should be answering the question? Do we need to get further—

Ms Beauchamp: 2.4.

CHAIR: I apologise, Senator Rice, for the incorrect information. Are you happy to ask the question in 2.4? We won't release the officers until the issue has been dealt with—just in case.

Senator RICE: All right. Are you going to do the rest of 2.3?

CHAIR: I'm going to ask my questions, because they're very important questions on this very important policy. This is 2.3. I am going to go through a few things in this area. I would like to start with the importance of the strategy of bringing back into the policy mix the underlying principle of getting workers into rural, regional and remote Australia who are actually trained in rural and regional Australia, and the need to develop the system and structures that actually train people in the bush. Can you talk us through the genesis of the package, with a particular focus on that element?

Senator McKenzie: I think the research shows us that there are two factors that will really determine or significantly impact on your decision to practise in the region. Those are: are

you of the regions—are you somebody who grew up in rural and regional Australia and have that embedded identity—or, have you undertaken a significant amount of training within your profession at the rural and regional level? There is much data going to that effect. So, in developing this package, what we've sought to do, particularly with the five end-to-end medical schools, is flip the training model, if you like, for medical training in this country. Traditionally, you would be at an urban university and you would enrol in your medical degree and you would pop out to the regions for an amount of time to undertake some of your training. What we've been able to do now is embed them in the regions for the entirety of their medical training, and they may pop back to a capital city to undertake very discrete units of training for the completion of their degree. So, I think we are going to see significant changes in medical graduates who set up practice in the region. David Hallinan has been intimately involved in the development of this package, which really is a comprehensive suite of initiatives—pull and push factors—that we think will deliver 3,000 doctors, 3,000 nurses and allied health professionals to the regions over the next 10 years, which is fantastic.

CHAIR: Do you have anything to add, Mr Hallinan?

Mr Hallinan: In summary, the package does target each stage of the training journey for medical practitioners, from undergraduate through junior doctor training years and then specialist training as general practitioners or other specialists. We've also attempted to improve the funding arrangements with students who have return-of-service obligations of the Commonwealth to work in rural areas, to support better distribution of that workforce and to create some incentive structures to support better qualification of practitioners delivering services in rural Australia.

CHAIR: When you talk about this end-to-end, how does it actually differ from what's happened in the past? The reason I ask this question is that I was in a country town in Western Australia last week that had lost a medical practitioner who worked in the hospital and in a GP setting. Obviously, they were very concerned about how they were going to attract the next generation of medical practitioners. So, can you talk about what's actually changed in the training system to try to improve that kind of nexus?

Mr Hallinan: Sure. The idea of an end-to-end training model is to let students enter their university training on day one in a rural location, and undertake that training throughout university primarily based in a rural location. If not for the entirety, there might be some visits into the city to do anatomy and other things that it might be better to do in the city. But, in effect, you're flipping the model. At the moment we have medical students trained, in large part, in the cities, with perhaps a one- or two-year rotation out into rural locations for clinical training. After they complete their medical degree, there are quite a few rural internships out there, currently. But there are fewer places for junior doctor positions beyond internships, for PGY2 and PGY3—that's probably meaningless—

CHAIR: A little bit meaningless to me!

Mr Hallinan: The second and third year out of university. There are fewer employment options for junior doctors. The package includes some reforms to Medicare arrangements to allow Australian-trained doctors to access Medicare in junior doctor positions for the first time outside of the formal General Practice Training Program, which would then assist with articulation into general practice or other speciality training in rural and regional locations. Fundamentally, the evidence that we've got says the longer we have people in a location the

more likely it is that they'll stay. So the underpinnings of the strategy are to try to remove any barriers that would stop people from staying in the regions in which they have trained and therefore support longer term outcomes for the community.

CHAIR: In terms of the problems for those in their second or third year out, was it a structural problem based on the fact that people would go to the bush and tend to stay there, so those junior positions were not available? Were there just not enough positions available in country hospitals?

Mr Hallinan: Regional and rural hospitals are slightly different from major city hospitals in terms of how they operate. Many rural hospitals are actually staffed by general practitioners with some additional skills in the sorts of services delivered in a hospital setting. In order to stay and practise in those communities, the practitioners need to both operate as a general practitioner in a general practice setting but also work in the hospital on a visiting medical officer basis. The existing settings, or the pre-existing settings, for accessing Medicare meant that, for that junior doctor period in particular, an Australian-trained practitioner would likely have to move to the city for their junior doctor training period because there wasn't the ability for them to work in that rural model, where you spend part of your time in a general practice setting and part of your time in a hospital setting. So some of these reforms allow those junior doctors to stay in the rural setting in a general practice setting while also working in the hospital as a longer term option, which we think will then support the development of a national rural generalist pathway that the Rural Health Commissioner has been asked to establish over the coming years.

CHAIR: Can you talk more about how those two things will intersect—that pathway and this package?

Mr Hallinan: The package itself is intended to remove any barriers that would get in the way of the development of the rural generalist pathway, but at this stage it doesn't deliver the rural generalist pathway. That's something that—

CHAIR: So this opens the door to training more doctors and nurses who will hopefully choose to make their careers in the bush. The pathway will then give them the journey along which they can travel?

Mr Hallinan: Yes. They could, yes.

CHAIR: In terms of numbers, it's 3,000 doctors and 3,000 nurses. Does it go to, I guess, nondoctors, nonnurses—allied health workers?

Mr Hallinan: Yes. There's a reform in the package to establish the Workforce Incentive Program. It combines two pre-existing programs, the Practice Nurse Incentive Program and the General Practice Rural Incentive Program, into a single, multidisciplinary Workforce Incentive Program. The reforms under that measure include allowing allied health to be an eligible profession, or set of professions, under the Workforce Incentive Program Arrangements, beyond the existing locations—at this stage, allied health incentives are available in areas of urban allied health workforce shortage, but nowhere else. That's a list of locations that's been identified through the Department of Human Services. This reform will allow allied health eligibility throughout the country, but particularly focusing on rural and remote areas to support better integrated care models in general practice settings throughout rural and regional and remote Australia.

CHAIR: Do you have any detail on how this will work in individual states? From a Western Australian rural point of view, can you give me any idea how this package will impact on the ground in Western Australia? If you can't, I accept that it's early days.

Senator McKenzie: I think a lot of initiatives use the Monash model around rurality, which is a lot more granular and specific than the older model. If you are truly rural, then you will receive incentives that you haven't necessarily been receiving before, and I was going to go to the detail of that. For instance, in WA, communities like Serpentine, et cetera, will be—and there's one that I can't—

Senator DEAN SMITH: Jarrahdale.

Senator RICE: Jarrahdale.

Senator McKenzie: There we go; I have three of you here now, you will between able to interpret for me. But, they'll be now able to receive an incentive, whereas previously they weren't. So, irrespective of your community, we've tailored this package to ensure that all of rural and regional Australia will be able to avail themselves. But, again, state governments will play a key role in that pipeline for the provision of further training places in state public hospitals.

CHAIR: I might be completely off beam here, but does the Curtin Medical School have any particular role in this package?

Mr Hallinan: Yes, it does. The Curtin Medical School through this measure will be established as part of the joint rural school clinical arrangements in WA, with both the other two universities in Western Australia delivering rural undergraduate training as part of their medical degree programs.

CHAIR: How much of that will take place—again, you may not have the detail on this—outside the Perth metro area? Obviously, all the universities are centred in the Perth and the main focus of the medical schools will be in Perth. Is Curtin going to establish an offshoot in a country town, for example?

Mr Hallinan: Yes, I think it will work collaboratively with the other existing sites, the other two universities in Western Australia.

CHAIR: So that will be in the hospitals and in the bush, basically?

Mr Hallinan: It will be, yes—on a distributed clinical training model. At least 25 per cent of their students must spend at least 12 months in rural clinical training through that expansion.

CHAIR: Can you compare that—and obviously Western Australia is very different in terms of population centres; I fully accept that—with what will happen with the Murray-Darling medical school network in New South Wales? How is that going to work—

Senator McKenzie: It's not just in New South Wales.

CHAIR: Oh, sorry.

Senator McKenzie: New South Wales and Victoria.

CHAIR: I'm from WA.

Senator McKenzie: It's all good. East coast.

CHAIR: East coast. The other side.

Senator McKenzie: That's right. The other side. I think it's issues that are fit for purpose. You will remember that Curtin got their CSP medical school places, and it was a significant win for WA to have another medical school set up there. I think this will actually build the capacity within WA in the regions. There will be three different schools operating and collaborating at the same time. In terms of how that compares, I imagine and the research would suggest, that graduates of the Murray-Darling medical school's network will be practising right throughout the country. The research suggests that you don't necessarily go back to where you've studied. You realise that working in the regions isn't a deficit and so you're prepared to go anywhere. For instance, I was at Charles Sturt University in Bathurst at their allied health campus and met a young training dentist from Mitta Mitta. And I said, 'Where are you expecting to practise?' He wanted to go back to Mitta Mitta, which is just outside of Wangaratta in Victoria. So I imagine these graduates will be right around the country.

CHAIR: I think I did ask this question at last estimates, but I will follow-up. You're confident that the research shows that doctors and nurses trained in the Murray-Darling medical school are more likely to stay in the bush no matter where it is?

Senator McKenzie: Absolutely. James Cook University has been running this model a lot. Charles Sturt University does it, not with medical graduates but with a lot of their allied health professionals, and there is very, very strong evidence that between 70 and 80 per cent of the graduates are still in the regions post-graduation, which is a great result. It is what this Senate committee found all those years ago. To be able to deliver on it, I think, is quite profound.

CHAIR: Excellent. Can I have a little bit of detail on the bulk-billing incentives. The description is that they are being 'better targeted'. Can you talk me through exactly how that is going to impact a medical practitioner on the ground—

Senator McKenzie: You won't be able to get it on the Sunshine Coast, but Mr Hallinan can go through the details.

CHAIR: I'd just like to get an understanding of what that better targeting actually means in practice. Again, if you can relate it to Western Australia, I'd love that. If you can't, that's fine.

Mr Hallinan: The package includes updating much of the underpinning rurality models that sit underneath a lot of the programs that we run in the health department for workforce policy measures. That means that we're moving from rurality measures—for instance, for bulk-billing incentives—that were derived out of 1991 population data to current or contemporary models of rurality measures. So we're moving them to the Modified Monash Model bulk-billing incentives from the old RRMA model. That means that locations that, in 1991 would have been identified as rural using 1991 census data, would no longer be identified as rural. For some parts of the country that were identified as urban at that stage, they'll no longer be identified as urban if they are, in fact, a rural setting. So the bulk-billing incentive update takes the old rurality measures and updates them to modern rurality measures. In WA, I think that would mean locations like Ellenbrook or Baldivis would no longer be eligible as rural settings for a rural bulk-billing incentive, and they would instead bill as an urban—

CHAIR: So, basically, areas that have urbanised are being removed. Have areas been added?

Senator McKENZIE: Yes, as I said, we've got a more granular approach than the RRMA, and I think—

CHAIR: So boundaries like—

Senator McKenzie: Areas like the Sunshine Coast and areas of Canberra have been able to access these incentives. We've changed the incentive programs to better target them to areas of need, so those communities that have fewer doctors and health professionals per thousand people actually get the money and the incentive, which is a great step forward.

CHAIR: It is. It's an excellent program.

Senator GRIFF: Professor Murphy, in the February estimates, in relation to mandatory reporting of mental health issues from doctors, you stated that COAG had not reached a final position, although the likely outcome of current deliberations was to remove the mandatory reporting requirements. Can you provide an update on this issue.

Prof. Murphy: COAG has, I think, reached a position at the moment. And the position is that—other than in Western Australia, which will continue its current position where there is no mandatory reporting—the reporting requirements in the other jurisdictions will be softened. If there is still a very serious risk of a practitioner putting patients at risk, there would be still a requirement to report, but the requirements have been softened a bit so that there isn't a concern from junior doctors that any mental health condition that they had in the past might lead to mandatory reporting. Mr Hallinan can perhaps give the exact wording of the COAG agreement.

Mr Hallinan: On 13 April ministers agreed to an exemption for reporting impairment unless, in the treating practitioner's reasonable view, the impairment is such that it would negatively impact the treatment of patients. They agreed to a requirement to report past, present and the risk of future of sexual misconduct, and a requirement to report current and the risk of future instances of intoxication at work and practice outside of accepted standards. There will be a draft bill, I think, tabled in Queensland later in 2018 to give effect to that decision.

Senator GRIFF: So that would also include anyone who has been reported in the past?

Mr Hallinan: In the case of sexual misconduct, it's a requirement to report past, present and the risk of future sexual misconduct, and, in the case of intoxication it's a requirement to report current and the risk of future instances of intoxication at work.

Senator GRIFF: Does reporting in that particular instance also apply to other practitioners registered by AHPRA?

Prof. Murphy: It applies to all registered health practitioners.

Senator GRIFF: I would also like to ask some questions about the $40 million in funding for drug and alcohol professional training with a rehab component that my colleague Rebekha Sharkie negotiated with the government earlier this year. The funding appears in the budget papers, but it does not appear to be new money. Budget paper No. 2 page 125 states, 'Funding for this measure has already been provided for by the Government.' Can the department

advise from where the funding for this program will be drawn? Is it being pulled from other programs or some other allocation?

Dr Studdert: Sorry, Senator, we were in the other room and I think we may have missed the nub of your question as we transited in here. I would be happy to try to answer it if you could repeat it.

Senator GRIFF: It's on the $40 million of funding which is allocated against professional training, which is why I'm bringing it up here, and also there is a rehab component there, too. The budget paper indicates that the funding for that measure has already been provided for by the government. So my question is: can you advise from where funding for the program will be drawn? Is it being pulled from another program or department allocation?

Dr Studdert: I think all I can say is that it's not being drawn from within the Health portfolio, and that it was provided for in the budget. We've worked closely with the Department of Social Services on this as part of their measures, but I don't have any visibility of the exact source of that fund.

Senator GRIFF: Can you advise when the program will start?

Dr Studdert: We will start discussions with the stakeholders involved in the coming weeks. My colleague here can say a bit more about that. The intention is that it would start to be rolled out in 2018-19.

Senator GRIFF: Can you advise or confirm how many doctors and allied health addiction specialists will benefit from the program?

Dr Studdert: Again, that's detail that we will work out in consultation with key stakeholders, GPs, primary health networks and service providers on the ground. It would be impossible or inappropriate to even speculate about that detail at this stage.

Senator GRIFF: The same, obviously, with locations for rehab facilities?

Dr Studdert: Exactly.

Senator GRIFF: All right. Thank you.

CHAIR: Senator Smith, did you have a final question before we go to the break?

Senator McKenzie: I can add two more towns from WA.

CHAIR: Please do.

Senator McKenzie: Two Rocks and Yanchep.

CHAIR: That's the northern end of Perth, but fair enough. That's the granularity you're talking about, Minister. Is everybody fine if we release program 2.3? Senator Rice is confident that her questions are going to be answered in 2.4. In that case, we will release program 2.3 with our thanks, and we shall suspend for one hour for dinner.

Proceedings suspended from 18:29 to 19:30

CHAIR: Okay. We resume with program 2.4, Preventative health and chronic disease support. Senator Rice, who has been waiting very patiently, has the call.

Senator RICE: Yes, finally here. Terrific. I have got some questions to ask about maternity services. I understand the National Maternity Services Plan concluded at the end of June 2016—so, almost two years ago—and that, since then, there's a new process underway to develop a national strategic approach to maternity services. That's correct?

Ms Beauchamp: That's correct.

Senator RICE: And that's currently open for consultation?

Ms Beauchamp: That's correct.

Senator RICE: Yes. Firstly, can you fill me in on how that consultation is going, what stage it's at and how much engagement you've had so far.

Ms Beauchamp: Under the auspices of the COAG Health Council, the officials have got together and asked us to take the lead on the development of the strategic plan. As you've mentioned, there is a consultation process underway, with a number of key stakeholders. I'll hand over to Ms Cole to provide you with all the details of the consultation process.

Ms Cole: Senator, first of all, I might not be able to provide quite as much detail as you'd like, because this process is actually being run by our Chief Nursing and Midwifery Officer, and she's currently on her way back from Howth, but I'll do the best that I can.

So there's an advisory group which has all the major stakeholders on it. There are about 25 different stakeholder groups, including consumers, on that group. It has obstetricians, midwives, general practitioners, academics and consumers from both the public and private sectors. That is the sort of standing consultation arrangement. They also have some nice diversity in terms of rural and regional settings, Aboriginal and Torres Strait Islander communities and all those sorts of things, and they're jointly co-chaired by an obstetrician, Professor David Ellwood; and a midwife, Ms Helen McCarthy. They will be with us, in a sense, throughout the process. Those co-chairs are also involved in the state and territory and Commonwealth discussion around the national strategic approach itself, so that we get those linkages. In addition, there are consultations being done right throughout Australia. I think the next one is actually in Toowoomba. There is also an online submission process, various workshops and focus groups.

Senator RICE: What's the time line for those consultation processes?

Ms Cole: This is where my detail is running out, Senator, so I will have to take that on notice for you.

Senator RICE: Okay. Do you know what the time line for the new strategic approach is?

Ms Cole: The outcomes of that consultation with the group and from the consultations around Australia are going to inform the new strategic approach. Then I think they'll go out for a further round of consultations before they finalise the approach.

Senator RICE: Right.

Ms Cole: So it's a while away.

Senator RICE: It's a while away. But you can't tell me when.

Ms Cole: No, I'm sorry, but I can take that on notice for you.

Senator RICE: Okay. Thank you. In terms of the old National Maternity Services Plan, I understand there was a commitment from the Australian health ministers in 2010 that there was going to be an evaluation of that plan done to inform development of the new national plan. Has that evaluation occurred?

Ms Cole: There was a final report done, but not an evaluation per se.

Senator RICE: Right. Does that mean the new strategy is going to be developed without a formal evaluation of the plan?

Ms Cole: That's right. There were reports, sort of progress reports, and a final report at the end of the previous plan, but not a formal evaluation per se.

Senator RICE: What was the process to decide that there wasn't going to be a formal evaluation, given that the health ministers decided in 2010 that there should be an evaluation of the plan? I would have thought evaluations were good practice.

Ms Cole: I believe that essentially the states and territories and Commonwealth didn't feel that there was much that could be added that wasn't already available in the reporting process that was already under way.

Senator RICE: So there's no independent review—a report of the people who were rolling out the plan? One of the purposes of an evaluation is to get an independent review, an independent look at what has been undertaken.

Ms Cole: I understand what you're saying, but that wasn't undertaken.

Senator RICE: Can you expand on the role and make-up of the strategy project reference group?

Ms Cole: The project reference group consists of senior officials from each jurisdiction. It's chaired by Ms Debra Thoms, who's our Commonwealth Chief Nursing and Midwifery Officer, who is unfortunately overseas at the moment. As I mentioned, the senior officials group, the project reference group, also has the co-chairs from the advisory group to run that context into play. So essentially it's a Commonwealth, state and territory group with the co-chairs from the advisory group also attending to bring that consultation level through.

Senator RICE: Are the any community representatives or consumer representatives on that reference group?

Ms Cole: On the advisory group there are, but not on the project reference group. The role of the chair, the co-chairs, is to bring through those views of all of the members of the advisory group. In addition, the consumers are being consulted on those broader consultations across Australia, and then the second round after the first round.

Senator RICE: They've been consulted with, but you haven't got consumer representation on the overall reference group?

Ms Cole: That's correct. The co-chairs from the advisory group have responsibility to bring forward the views of that whole group, which includes the consumers.

Senator RICE: Was there a particular reason to exclude community representation from that reference group?

Ms Cole: The reference group itself is primarily meant to be where the states and territories discuss and collaborate, and also sometimes disagree, on what the final national plan will look like. Often in these circumstances you'll only have a state and territory and Commonwealth group doing that final consultation. In this case they've actually brought in the two co-chairs to make sure it is informed by community views.

Senator RICE: So they've been channelled by that. Going on to the advisory group and the reference group, are they considering the broad range of issues like funding, work force and such things?

Ms Cole: There is a discussion paper, I believe, on these issues more generally. I expect a huge range of issues in maternity services and strong views will be expressed throughout all the consultation processes.

Senator RICE: Are there terms of reference for the project reference group and the advisory group?

Ms Cole: There are, and I can see whether they can be tabled.

Senator RICE: That would be very useful. So you feel that the scope of the advisory group is broad enough to consider the full range of issues that will be brought up in consultation?

Ms Cole: Whether the final plan incorporates every issue that's brought up is a different issue, but I think that the consultation process is so wide that all of those sorts of issues you mentioned will be canvassed one way or the other.

Senator RICE: Can you comment, either from what was in the old plan or what's being considered for the new plan, on the importance of women being able to access continuity of care when it comes to midwifery services?

Ms Cole: Continuity of care generally is very important for all patients within the health system, particularly over the course of the service where there are many episodes. However, this is not actually an area in which I'm an expert in terms of the clinical needs or clinical benefits. I wonder whether our CMO or deputy CMO might be able to help on that issue?

Prof. Murphy: I can briefly comment because I've had discussions about this advisory group with some of the members. I think a very clear part of their role is to look at providing high-quality access to midwifery care in an integrated framework. There are clearly some issues with community based midwifery care working in isolation at the moment. I think that's one of the key issues that this advisory committee is undertaking to look at. That's what I've been advised, anyway.

Senator RICE: So continuity of care of midwifery services is a key issue to be looked at?

Prof. Murphy: Yes. There's strong representation of midwifery on the advisory group. In fact, I had to reassure the medical members of the advisory group that it wasn't going to be an entirely midwifery based advisory group. So there's a good balance and a very strong midwifery representation, who are putting their case very well, I'm told.

Senator RICE: Given the importance of the continuity of care for midwifery services, are there any plans for mechanisms to encourage, or is it expected to have mechanisms to encourage the states and territories to restructure their maternity services to make sure that women have continuity of care for midwifery services?

Prof. Murphy: That's a big issue. I think only Queensland really has any sort of formal structure where community based midwives are integrated into the public health sector. Some other states and territories have birthing units, but they don't tend to have that same link with community based midwives. That is a big issue because privately practicing midwifery is in a very uncertain situation at the moment because of insurance and all those issues. There is a strong view from some of the obstetric doctors and some of the midwives that the public birthing systems in the states and territories should have a better incorporation of midwives. At the moment, as I said, only Queensland seems to have developed that sort of model. I'm

sure the advisory group will be encouraging the other states and territories to look at those models.

Senator RICE: You'd then be looking at whether there were mechanisms, potentially funding mechanisms, to get states and territories to improve their practices?

Prof. Murphy: The states and territories are responsible for those services. The Commonwealth provides its share of money through the National Health Agreements, but ultimately the provision of and the nature of those services are a matter for the states and territories. As I said, Queensland have developed their model. I'm sure there will be encouragement from this group to do some more work in that space.

Senator RICE: The other issue related to that is data collection. I'm interested to know whether there are plans at this stage, going into this review, to be measuring and reporting on women's access to continuity of care.

Prof. Murphy: I'm not aware of that sort of detail. That could be taken on notice to answer for Ms Cole or for Ms Thoms to answer when she comes back.

Ms Edwards: Can I add one thing? The discussion paper that Ms Cole referred to is a consultation paper and is available on our website. It does cover some data and the range of issues that are being considered. It's available on our website.

Senator RICE: And it probably says on the website what the timing of the process is going to be.

Ms Beauchamp: I think the consultation process is due to be completed on 18 June. There are a range of questions that are being asked. To go to your point about continuity of care, it's looking at all the different models of care that apply and making sure that there are improved health outcomes for mothers going through pregnancy and post for the child and the mother as well. I think that absolutely should pick up what the best pathway of care is depending on the individual.

Senator RICE: Some of the midwifery people, given they haven't got that sort of community representation on the project reference group, are concerned that those issues aren't going to end up coming out at the forefront, as they believe they should.

Prof. Murphy: My understanding is that the advisory group is very powerful advice and is providing most of the information. The reference group is coordinating the process, but the advisory group is providing very strong and forthright input into the plan. That was the impression I was given.

Ms Edwards: That's certainly my understanding also. It's a broad range across the whole spectrum, and it is definitely the case that the consultation process is scheduled for May and June with public submissions due on 18 June. Ms Thoms will know more on the timeline, but it also depends a bit on the Commonwealth and state relations meetings and so on. Obviously, this is something that has been commissioned by the Health Ministers' Advisory Council, so it'll go back, through the reference group, to be considered at that high level—we think, later this year, but the exact timing we will take on notice.

Senator RICE: Is it a concern that the previous plan was only meant to be until 2015—it was completed almost two years ago now—and it sounds like it's going to be still quite a lengthy period of time before we have this new strategic approach finalised?

Ms Beauchamp: I think the consultation paper actually refers to the previous plan and the report that Ms Cole referred to and what's been done with it. So that will absolutely feed in to this next plan. It's not as if there's been nothing happening as a response. I think there are annual progress reports provided, and this final report, and the attachment to the consultation paper, from my memory, says what has happened with each of those recommendations. So the advisory group and the consultation process will pick up some of those comments.

Senator URQUHART: I just want to ask some questions around the Local Drug Action Teams. Last year in April, Minister Hunt put out a media release confirming the Local Drug Action Team for Burnie, and, in September last year, then Senator Parry put out a media release confirming a Local Drug Action Team for Devonport. Is a similar service offered in Smithton, in the far north-west of the state?

Dr Studdert: My colleague David Laffan has a detailed list here. So I think he can identify—

Mr Laffan: I'm not exactly familiar with the area that you're talking about, but there are now six Local Drug Action Teams in Tasmania.

Senator URQUHART: Can you just tell me where they are?

Mr Laffan: I can, by electorate. So there's Braddon; three in Lyons; one that crosses over Clark and Lyons—sorry; there are two in Braddon—

Senator URQUHART: Have you got the towns?

Senator McKenzie: Rather than electorates, let's do towns. They're big electorates.

Mr Laffan: There is Burnie Works, which is in Burnie City Council. There is Huon Valley, and the organisation there is Rural Alive and Well. There's a south-east healthy and resilient communities—again, Rural Alive and Well; the Devonport hub committee; the Glenorchy Healthy Active Preventive Program for Youth, and Glenorchy City Council; and one in the Circular Head Aboriginal Corporation—

Senator URQUHART: So there is one in Smithton? That's where Circular Head is.

Senator McKenzie: Local knowledge is important.

Senator URQUHART: Absolutely. Can you provide me with an update on the rollout of these services?

Mr Laffan: Certainly. As you're aware, both the first two rounds were previously announced. The third round of the Local Drug Action Teams was announced on the weekend by the minister—

Senator McKenzie: In Darwin.

Mr Laffan: So broadly, for Australia, there are now 172 Local Drug Action Teams around the country. In that third round, which was announced by the minister on the weekend, an additional 92 LDATs were added to the program.

Senator URQUHART: What about the Tasmanian ones? Can you give me a brief update on them?

Mr Laffan: I can tell you that they are all at various stages. The two that have just been announced in round 3 will have their $10,000 grant for putting together their community action plan and working with the Alcohol and Drug Foundation.

Senator URQUHART: Was that Circular Head one announced in round 3, did you say?

Mr Laffan: Yes, it was.

Senator URQUHART: So that's just been announced. I don't want all the information across Australia; I'm from Tassie. How much funding did each of the sites receive for Tassie?

Mr Laffan: Each of the six local drug action teams have received $10,000.

Senator URQUHART: So it's the same for all of them?

Senator McKenzie: That's to develop their plan. Then, if they require further resources to implement their plan, we've got up to $40,000 for those teams to access.

CHAIR: How many have accessed the $40,000 so far?

Senator McKenzie: A range over rounds 1 and 2. The median amount accessed is around $10,000 to $15,000, because most of these LDATs are groups that are already working in communities. It's about joining up their service delivery.

Senator URQUHART: Is the funding being distributed on a per capita basis?

Mr Laffan: There's roughly the allocation for local drug action teams to be matched to each jurisdiction on a per capita basis, but there is a competitive round for these organisations that apply for this program and so it might not match that when the full rollout's achieved.

Senator URQUHART: So is it correct that $19.2 million has been allocated for the local teams?

Mr Laffan: $19.2 million has been allocated for the program, yes.

Senator URQUHART: How much of that funding has been allocated for Tasmania?

Dr Studdert: Again, it's not allocated on a per capita basis; it's a competitive process. We look to make sure there are opportunities and supports for action teams all across the country and we have a mind to some equitable distribution, but it does have to be on the quality of the proposals.

Senator URQUHART: So the six sites around Tasmania will all be involved in a competitive tender, but they'll also be involved—

Senator McKenzie: No, they've been successful already in competitive tenders at rounds 1, 2 and 3.

Dr Studdert: They're now resourced to go and develop their plan with their communities, and the allocation of funds is then based on what their communities identify as being opportunities and areas of need where they can work.

Senator URQUHART: Have there been any further application from the north-west and west coast of Tasmania for local drug action teams?

Mr Laffan: I don't have any information about local drug action teams that weren't successful in this round.

Senator URQUHART: Can you tell me how many drug and alcohol rehab services are available in Tasmania's north-west and west coast?

Dr Studdert: That's a different funding stream. That's for drug and alcohol treatment services.

CHAIR: I have a couple of questions on LDATs before we move on. You can probably take them on notice. There are 172 local drug action teams so far; is that right?

Mr Laffan: Yes.

CHAIR: Can I have the number in Western Australia but particularly—and I'm happy for you to take this on notice—the number in regional WA.

Mr Laffan: I can tell you that there are 25 local drug action teams in WA. I don't have that broken down by region, but what I can tell you is that, of the 172 LDATS, at least 44 of those are in areas supporting the needs of Aboriginal and Torres Strait Islander people. That is a quarter of those drug action teams.

CHAIR: On notice, can I have the 25 locations for Western Australia. Then I can work out whether they're regional or not.

Mr Laffan: Sure. I do have them, but I think it will take some time to read them.

CHAIR: That's fine. I'm not going to do anything with them tonight. Can you give us a sense of the range of activities that are being undertaken. Are we seeing a lot of variety or are we seeing a lot of similar themes?

Mr Laffan: There are quite a few similar themes across the country, and that's because they're being supported by the alcohol and drug foundations, which have quite a wide range of support tools ensuring that the activities undertaken are evidence based. So we have some activities which are broadly in the community working with people potentially of low-socioeconomic status. Other local drug action teams will be working in mentoring types of programs in local schools. So there is a significant range out there.

CHAIR: So the funding has been focused on providing evidence based models rather than looking to let 1,000 flowers bloom and then get the evidence back from those trials? Or are we doing a bit of both?

Dr Studdert: It is a bit of both. They're supported by the Alcohol and Drug Foundation with its knowledge and evidence base but it is very much tailored to and responsive to local needs and opportunities.

CHAIR: Is part of the process the foundations drawing that information back to what's working on the ground?

Dr Studdert: Absolutely. Yes.

Senator URQUHART: You were finding out how many drug and rehab services were available in the north-west and west coast?

Dr Studdert: We can tell you about details of some of the ones we provide funding to but that would not be a full picture of drug and alcohol treatments services, given a lot of them are funded by the state.

Senator URQUHART: Sure.

Mr Laffan: I don't have the information broken down by region but I do have the information for Tasmania. For rehabilitation projects, there aren't any that are funded specifically by the Commonwealth in Tasmania.

Senator URQUHART: None at all?

Mr Laffan: Certainly not directly, as in managed by the department.

Dr Studdert: I think that's residential rehab, specifically. We have other treatment services.

Senator URQUHART: Tell me what you've got. How many residential rehab beds are available in Tasmania and how many in the North West and West Coast?

Dr Studdert: We don't have that information. Availability of residential rehab beds is not a data set that we maintain.

Senator URQUHART: Is that because you don't fund them?

Dr Studdert: We're not funding any. The data we have here is we're not funding any residential rehab. So our Primary Health Network in Tasmania has distributed some funding for treatment and services. But in their process and assessment of where there was need and where they engaged with the community, they haven't funded residentials specifically but they will have funded other forms of treatment services.

Senator URQUHART: Can I jump back to the Circular Head round 3 that you talked about. I understand that's $10,000.

Dr Studdert: That's their initial funding they get to work with their community to identify other needs, hold forums.

Senator URQUHART: When they identify the other needs, do they then put together a submission?

Mr Laffan: They'll work with the Alcohol and Drug Foundation. They will formulate a plan that is evidence based in conjunction with that organisation and then there will be opportunity in future times to apply for additional grant funding to implement that activity.

Senator URQUHART: When you say 'future times', how often does that come round?

Mr Laffan: They have been, in the past, twice a year, but I don't have in front of me at what point in time the next one will be available. But certainly particularly for the LDATS that have been established as part of round 3, there's a six-month process they work through with the Alcohol and Drug Foundation to finalise what that plan is and then they'd be in a position to seek additional funding.

Senator URQUHART: So they have six months to organise the plan and then they would be in a position to put forward that submission for funding, but you can't tell me when the next round of funding is?

Mr Laffan: I don't have that in front of me.

Senator URQUHART: Do you have it somewhere?

Mr Laffan: I will be able to get you some information about that, yes.

Senator URQUHART: Are you able to get that during the course of the hearing? I'm interested because there are reports of one in 10 people using ice within that Circular Head region. So I'm really interested in the time frame to try and sort of understand just what is going on there.

Dr Studdert: We'll see what we can find out for you and come back to you tomorrow.

Senator URQUHART: That would be great, thank you.

Senator SIEWERT: I should be fairly quick. I wanted to follow up the FASD strategy and the question you took on notice last time, where you said that following the consultation

process undertaken in late 2017, you were preparing a draft of the strategic action plan for discussion with state and territories at the first meeting of the National Drug Strategy Committee and Ministerial Drug and Alcohol Forum this year. Has that happened?

Mr Laffan: Yes, it certainly has. We have the draft of the strategic action plan. It was discussed at the National Drug Strategy Committee to go to a working group with the states and territories negotiating the finalisation of what might be put forward to the Ministerial Drug and Alcohol Forum. That Ministerial Drug and Alcohol Forum meets in the middle of next month, and it may note the plan at that point in time. We hope that the strategic action plan is finalised before the end of this year.

Senator SIEWERT: So it has gone to the states and territories working group?

Mr Laffan: Yes, we're working with the states and territories quite closely now in terms of refining that strategic action plan.

Senator SIEWERT: And then it goes back to the ministerial council?

Mr Laffan: Ministers at the Ministerial Drug and Alcohol Forum will have the opportunity to comment on that in the middle of next month. Any views that they express in relation to the strategic action plan will be taken into account and officials will, through the working group, finalise that plan and then provide it forward to the Drug Strategy Committee and subsequently to the Ministerial Drug and Alcohol Forum for consideration.

Dr Studdert: Just to be clear: the Ministerial Drug and Alcohol Forum will meet in the middle of next month, as my colleague said, and then again towards the end of next year. Depending on their consideration and the issues they identify, it could go to them out of session or they could ask for it to come back to them at the later meeting.

Senator SIEWERT: So that's the second one towards the end of the year?

Dr Studdert: Yes.

Senator SIEWERT: The ministerial forum?

Dr Studdert: So it won't be finalised for this one in June, but it will be finalised following that, given the guidance we get from ministers at that forum. As David said, our intention is to finalise it, but we'll obviously need to be directed by ministers.

Senator SIEWERT: Has anybody outside of government had a chance to comment on the draft strategic action plan? Has it gone to any stakeholders or any outside expertise?

Mr Laffan: Certainly the strategic action plan was formulated after quite extensive consultation and feedback from a significant number of people.

Senator SIEWERT: Feedback on a draft or just asking them questions? Seeing the draft strategy and commenting on that is a very different process to being consulted.

Mr Laffan: Sure. No, that hasn't been the subject of further consultation at this time.

Senator SIEWERT: Would that not be appropriate so that those with expertise in the area outside of government get a chance? I can think of a number even in my home state of Western Australia, let alone the rest of Australia—

Dr Studdert: Certainly, there's a lot of expertise.

Senator SIEWERT: Would it not be appropriate to get some feedback from those experts who have literally spent years working on this?

Dr Studdert: As Mr Laffan said, there has already been a lot of input from those experts. I think they would say that we've worked closely—

Senator SIEWERT: With all due respect—

Dr Studdert: But I see your point and we will seek advice from the ministers on that following the meeting.

Senator SIEWERT: You will ask them whether you can actually show the draft to people with expertise in the area? There is a very big difference between asking people what the issues are and consulting with them and letting them actually look at what you're planning to do.

Dr Studdert: I acknowledge that point. We can certainly make the ministerial forum aware of the interest in seeing the draft and get further advice from them at the time.

Senator SIEWERT: Normally it going out for public comment would be useful. But, in the absence of that, at least people with expertise seeing it I would have thought would have been—

Dr Studdert: That's certainly an option—targeted consultation or broader public consultation. As the representative on the National Drug Strategy Committee, which is the senior officials, I can certainly take it on to make ministers aware of that interest.

Senator SIEWERT: Thank you. I look forward to hearing more about it at next estimates.

Senator WATT: I've got some questions about the National Cancer Screening Register. Thanks for joining us. Ms Konti, I don't know if you're the person to direct questions to in the first instance. I remember we talked about this last time. We learnt at previous estimates that the government initially said that the Bowel Cancer Screening Program would move onto the National Cancer Screening Register in March 2017. There have obviously been some delays. Last estimates you told us that it would more likely be in 2019, so a two-year delay. Do you have a more definite target date for us?

Ms Konti: As I think we might have stated at the last estimates, the planning for the bowel cancer screening register transition will recommence once we have finished migrating the state and territory cervical screening registers and have that up and running. That is due to be completed by the end of June this year.

Senator WATT: I remember you saying that essentially you had been put on hold until the cervical cancer register is up and running. That is still the case?

Ms Konti: That is still the case.

Senator WATT: And you have no idea whatsoever about a start date for the bowel cancer screening register?

Ms Konti: It will likely be in the latter half of 2019.

Senator WATT: That would be 2½ years after the government initially said. What do the ongoing delays here mean for Telstra's contract with the government?

Ms Konti: So far, Telstra have been paid less than $11 million under the contract. They will commence being paid full operations for the cervical screening register once that is delivered at the end of June.

Dr Studdert: I think it is safe to say there have been delays in payments to Telstra.

Senator WATT: There have been delays in payments to Telstra?

Dr Studdert: Absolutely.

Senator WATT: Because they are not meeting their milestones and requirements under the contract?

Dr Studdert: Correct.

Senator WATT: Have there been any penalties against Telstra, as opposed to simply not paying them for work they've done?

Ms Konti: The way we are managing the contract is to pay them once the work is complete.

Senator WATT: There are no penalties that they need to pay the department for failing to meet milestones as you might get under a construction contract or something like that?

Ms Konti: Not at this stage?

Ms Beauchamp: At this stage we haven't looked at penalties.

Senator WATT: Is that an option?

Ms Beauchamp: It is certainly an option in the future but we haven't taken that course of action.

Senator WATT: So there is provision in the contract for penalties to be issued?

Ms Konti: Yes.

Senator WATT: Equally, is there provision in the contract for Telstra to impose penalties on the department if they feel that you haven't met your side of the bargain?

Ms Konti: No.

Senator WATT: There is no provision in the contract for that to happen?

Ms Konti: There is provision in the contract for typical dispute resolution and there are health supplied items that are listed in the contract—those kinds of things. If those items are not supplied, that could constitute what is called an excusable event under the contract terms. But there is no provision for penalties.

Senator WATT: Given these delays would the Commonwealth now be within its contractual rights to cancel Telstra's contract as it relates to the Bowel Cancer Screening Program?

Ms Konti: It could consider that course of action. We haven't taken that course of action at this point.

Senator WATT: Have you sought any advice about your ability to terminate the contract?

Dr Studdert: Not at this stage.

Senator WATT: But there is provision under the contract for it to be terminated for the sorts of things that have occurred or not occurred?

Ms Konti: Yes.

Senator WATT: Is there any point where you would actively consider terminating the contract given the ongoing delays?

Dr Studdert: At this stage we are very focused on working with Telstra to deliver what was contracted for. There is still a lot of value to be obtained from establishing a single national cancer screening register and that is the focus of the work and efforts at this stage.

Ms Beauchamp: I think there is also acknowledgement that it was a very complex project. The learnings coming out of the national cancer screening register will absolutely be used in developing the transfer of the national bowel cancer screening register from DHS to the new register. So we will absolutely be able to take some lessons from the current process.

Senator WATT: As I think I have done at previous estimates, I might just remind you of the evidence we received from the department at the Senate inquiry on the legislation required to set up this register. We were told that we had to urgently pass this legislation because the inefficient paper based processes that we have for the National Bowel Cancer Screening Register mean that, for example, when women move interstate their records and capacity to be supported and followed up by a screening register can slip through the cracks. So, given the department's evidence, isn't it the case that this delay is jeopardising people's health and safety?

Dr Studdert: Senator, just to be clear, the Bowel Cancer Screening Register is already a national register. It is run by DHS.

Senator WATT: Yes, but it's paper based.

Dr Studdert: There are paper based elements of it, which could be more efficiently run. So, a woman moving interstate or any Australian moving interstate won't make a difference to that particular part of screening operations. I think the challenge has been around cervical screening, where different jurisdictions have had different registers and there have been challenges for women when they move interstate. Certainly one of the reasons for prioritising the establishment of that part of the national register is to address that inefficiency and risk, and that is now well advanced and underway.

Senator WATT: Just on this point about the existing services that you say cover the gaps, for the moment, I understand that states and territories only have screening results up to 1 December 2017. Is that correct?

Ms Konti: That's correct. Because all of the pathology test results beyond 1 December 2017 for cervical screening tests, or any cervical pathology, are in the National Cancer Screening Register.

Senator WATT: But it isn't up and running yet.

Ms Konti: The National Cancer Screening Register was implemented on 1 December 2017 to support the new screening test. This was part of a planned and phased approach in conjunction with the states and territories to do joint operations of a renewed cervical screening program until such time as the remainder of the functions of the register were available.

Senator WATT: As I understand it—and correct me if I am wrong—while the National Cancer Screening Register has been set up, the screening history function is not yet up and running? That has yet to be—

Dr Studdert: But that has continued to be available from the states and territories. So it is a bit of a hybrid model at this stage, where we're using results and screening histories from the

states and territories where they're required based on the pathology that comes in on recent screens.

Senator WATT: But isn't the problem that, if states and territories only have screening results up to 1 December 2017, those state and territory screening systems miss any tests undertaken after 1 December. Given the National Cancer Screening Register isn't yet providing this screening history function, doesn't that mean that labs are now getting screening histories that are several months out of date?

Ms Konti: Laboratories can get screening histories pre 1 December from the state and territory registers. They can also obtain post 1 December screening histories from the National Cancer Screening Register. The process is phone and fax based. The National Cancer Screening Register, in addition to receiving pathology test results since 1 December 2017, is also following up on all of those new tests, from the point of view of high-grade results, cancer results and other kinds of results. So, all of those follow-up functions are being conducted by the National Cancer Screening Register operator staff, which have been in place since 1 December last year.

Senator WATT: Thanks. I will leave it at that in the interests of time.

CHAIR: I have just a couple of final points on this issue. Just to be really clear, to reassure people, there has been no impact on patient services or access to records during this transition phase?

Dr Studdert: Absolutely not.

Ms Konti: No gap in service. That was one of the reasons why we undertook this phased-implementation approach.

CHAIR: Is there anything beyond what you've already described in the terms of the arrangements during the transition phase? I mean, we're dealing with this hybrid model.

Ms Konti: The transition phase is underway right now, and that involves three things. It involves the migration of the state and territory registers over into the National Cancer Screening Register. So far, we have five of the eight states and territories successfully having migrated into that register, along with the Medicare data. One of the state or territory is verifying and reconciling the results of their migration, which is complete, which makes the sixth one. The seventh one is underway, and Victoria is yet to come. That is expected to be finished by 8 June. After that time all of the pathology test results that have been collected by the National Cancer Screening Register since 1 December last year will be matched to participant records and applied to them. Then the services will be complete.

CHAIR: That last part of the puzzle—

Ms Konti: 29 June is the delivery date for that, and we are on track for that.

CHAIR: Excellent. Thank you very much.

Senator DI NATALE: I have some questions about the pill-testing trial that was conducted at the festival in Canberra in April this year. I want to know whether the federal government has any plan to support the introduction of pill-testing services more broader as part of a national harm reduction strategy?

Dr Studdert: There are no plans, no.

Senator DI NATALE: Given that the National Drug Strategy signed off by all health ministers takes a harm minimisation approach—obviously, the three pillars being demand reduction, supply reduction and harm reduction, and harm reduction is described as reducing the adverse health, social and economic consequences of the use of drugs for the user, their families and the wider community—why isn't this consistent with the government's own National Drug Strategy?

Dr Studdert: It is a national strategy and all the state and territory governments, along with the national government, are signed up to it and each jurisdiction will pursue a range of measures on of those pillars, and they will vary across each jurisdiction, depending on priorities and opportunities. At this stage that is not on the national government's planning horizon.

Senator McKenzie: In terms of harm minimisation, in our approach some of the LDATs we were talking about earlier really focus strategies around harm minimisation, not just prevention. So, across the whole suite of government initiatives in this space we do hold true to our support of harm minimisation, obviously.

Senator DI NATALE: I'm interested as to why pill testing doesn't fit within the definition that the government signed on to.

Dr Studdert: I don't think we're saying it doesn't. I think that it is just that it is not something the federal government has a particular role or part to play in.

Senator DI NATALE: Doesn't have a role to play in?

Dr Studdert: The settings in which that occurs are largely under the jurisdiction of state and territory planning authorities.

Senator DI NATALE: I understand the government provided information during its budget lock-up—during the health briefing—that about $40 million was allocated for new drug and alcohol initiatives. Can you outline in detail what these specific measures are?

Dr Studdert: I think you're referring to the measure we talked with Senator Griff about earlier, which was an announcement around funding for education and awareness around treatment services, and some residential rehab and other treatment services.

Senator DI NATALE: What is education awareness?

Mr Laffan: The first part of that measure was in relation to supporting professional development in primary care for treatment of alcohol and drug abuse. The second component of that was in relation to drug rehabilitation services.

Senator DI NATALE: What does the professional development in primary care look like? Is that educating GPs?

Dr Studdert: I think that's something we're still planning with GPs and other primary care providers.

Senator DI NATALE: How much is allocated for that component?

Dr Studdert: $20 million for that element, and then $20 million—

Senator DI NATALE: $20 million for professional development in primary care? What is that?

Dr Studdert: The details are to be worked out. We're consulting with the primary health networks—

Senator DI NATALE: Surely you must have an idea about what that means? Are we talking about methadone treatment? What are we talking about?

Dr Studdert: I think it will be a range of measures—

Senator DI NATALE: Such as—

Dr Studdert: but we haven't finalised any specific details at this stage.

Senator DI NATALE: So you just throw $20 million—

Dr Studdert: No, we're not throwing money anywhere until we have had consultation and come up with a plan for what those—

Senator DI NATALE: You don't allocate $20 million for professional development unless you have an idea about what you're trying to develop.

Mr Laffan: We'll continue to work with stakeholders in relation to both of the elements of that measure and then the final scope of the—

Senator DI NATALE: Why was the allocation made if you didn't have that work done already?

Dr Studdert: I think there was discussion with stakeholders that this was an area of need and an opportunity—

Senator DI NATALE: What was an area of need?

Dr Studdert: Professional development in—

Senator DI NATALE: In what area?

Dr Studdert: For primary care professionals.

Senator DI NATALE: That is so general. Come on; you must have an idea about what you're looking to allocate $20 million for.

Senator McKenzie: I think the officer has answered your question. She said that's—

Senator DI NATALE: No, she hasn't, which is why I'm continuing to ask the question.

Senator McKenzie: She has, actually, Senator Di Natale. She has outlined that that is a piece of work that, on advice of stakeholders, is $20 million, and they'll be preparing a plan of primary care—

Senator DI NATALE: What was the advice from stakeholders? What did the stakeholders ask that the money be spent on?

Dr Studdert: There are opportunities in primary care settings to work with clients that are interested in or in need of primary care services in relation to drug and alcohol harms, and—

CHAIR: Senator Di Natale, are we covering a couple of programs?

Senator DI NATALE: No, we're in 2.4, Preventative Health and Chronic Disease Support.

CHAIR: Okay.

Ms Beauchamp: It's being provided over three years—so we're not rushing to do this. It is absolutely to help frontline workers care for the treatment and support of people with drug abuse and also for residential rehab services.

Senator DI NATALE: I'll get to the rehab in a minute. Half of the $40 million is in professional development. Did you say GPs?

Dr Studdert: It will include GPs.

Ms Beauchamp: Including GPs and allied health professionals.

Senator DI NATALE: But not limited to GPs?

Dr Studdert: Not limited to GPs.

Senator DI NATALE: Drug and alcohol treatment workers?

Dr Studdert: It could include them, yes.

Senator DI NATALE: Could include them?

Dr Studdert: Again, we will consult on the detail and get further information together on where the appropriate targeting and opportunities are.

Senator DI NATALE: So at this stage there's $20 million in some nebulous pool called 'professional development'?

Dr Studdert: I don't think it is nebulous, Senator. We've received advice that there is an opportunity and need in the community from primary care providers and we're looking to respond to that. The detail will be developed.

Senator DI NATALE: I just thought that if GP needed professional development in this space it might be around methadone prescribing—'Can we have some more support, so that we can go on and provide opiate substitution treatment,' or it might be around what the particular responses to detox are. There's a whole bunch of—

Dr Studdert: And I think they're all completely in scope.

Senator DI NATALE: They're all in scope?

Dr Studdert: Absolutely.

Ms Beauchamp: We'll make sure they're not nebulous and that they are well targeted and pick up exactly the sorts of questions that you're raising.

Senator DI NATALE: I want to ask about the drug rehab. What's that going to?

Dr Studdert: Again, there are details to be worked out in consultation with primary health networks and they will respond to areas of need for treatment services.

Senator DI NATALE: So we don't know what areas of drug rehab. Are we talking about therapeutic communities?

Dr Studdert: Absolutely.

Senator DI NATALE: So, again, just drug rehab.

Dr Studdert: And then responding to areas of need.

Senator DI NATALE: So $40 million was allocated to two very broad areas but there is no detail about how that money is going to be spent.

Dr Studdert: With a commitment to work on the detail with stakeholders.

Senator DI NATALE: Is the funding committed to a particular geographic region?

Dr Studdert: The funding for treatment services is committed to South Australia.

Senator DI NATALE: It is committed to South Australia?

Dr Studdert: And the rest of the funding is for primary care professional—

Senator DI NATALE: Why South Australia?

Dr Studdert: That was a decision of government.

Senator DI NATALE: Minister, does this have something to do with a particular arrangement with NXT and Centre Alliance that's related to the welfare testing bill?

Senator McKenzie: I'll have to take that on notice, Senator Di Natale.

Senator DI NATALE: Why South Australia, Minister?

Senator McKenzie: This is area—

Senator DI NATALE: Is there a particular problem with drug use—

Senator McKenzie: Senator Di Natale, you asked me a question; please allow me to answer it.

Senator DI NATALE: I hadn't finished asking the question.

Senator McKenzie: Okay.

Senator DI NATALE: Is there a particular issue in South Australia that warrants funding over and above other states when it comes to drug and alcohol use and abuse?

Senator McKenzie: I'm not sure, Senator Di Natale. I'll consult Minister Hunt and get back to you.

Senator DI NATALE: So just to be clear: is the $20 million for professional development or drug treatment? Which one of those is confined to South Australia?

Dr Studdert: The treatment services.

Senator DI NATALE: So, in this budget, the only additional funding for treatment services is in South Australia?

Dr Studdert: I think that's correct, Senator, yes.

Senator DI NATALE: Where are the trials of drug testing currently engaged in that the government is looking to associate with these welfare measures—what states?

Mr Laffan: Senator, as you are aware, the legislation in relation to the drug-testing trial is before the House at the moment, and it was, I understand, intended that the three locations for that were to be Logan in Queensland, Canterbury Bankstown in New South Wales and Mandurah in WA.

Senator DI NATALE: So South Australia is not one of the states where trials are going to go ahead and yet you've decided to commit $20 million to a place that's not even associated with the trial, based on no evidence that there's a different prevalence or specific problems in South Australia compared with other states?

CHAIR: The minister took the last half of that question—

Senator DI NATALE: No, I'm asking Dr Studdert.

Senator McKenzie: I've taken that on notice.

Senator DI NATALE: I've just asked Dr Studdert.

Dr Studdert: I think that, as you know, there is a range of services that the Commonwealth funds around the country. This is additional funding for South Australia, and I don't think that it will go wanting for appropriate use and allocation to services—

Senator DI NATALE: Did you provide advice to the government that this was necessary in South Australia as compared to other states?

Mr Hehir: No, Senator.

Senator DI NATALE: Do you have access to any information that would allow you to draw the conclusion that South Australia has a problem that doesn't exist in other states?

Dr Studdert: I think as I said, that we hear regularly about jurisdictions—all jurisdictions—having areas of need, and we work proactively through the Primary Health Networks and with our colleagues in the states and territories to address those as best we can, when we can, through the funding sources we have available.

Senator DI NATALE: Perhaps I'll ask you the question in a slightly different way. Does this allocation of funding have any relationship with the welfare-testing bill?

Senator McKenzie: Sorry, Senator Di Natale, can you repeat the question?

Senator DI NATALE: I'm just asking whether the allocation of funds, the $20 million that goes just to South Australia, has any relationship with the welfare-testing bill.

Senator McKenzie: Not to my knowledge.

Senator DI NATALE: Has the department received any applications or requests for funding from other state jurisdictions?

Dr Studdert: We're always, as I said, in consultation with our colleagues through the Primary Health Networks, through the work we're doing with funding services through them, and through our state and territory colleagues. I would have to say that we receive a range of applications. We're not always able to respond to them but we use those to develop our understanding and knowledge of the services out there and where there are areas of need.

Ms Beauchamp: Sorry, Senator, can I also add that this is already on top of what was announced in the 2016-17 budget about the $561 million—

Senator DI NATALE: Sure, I'm aware of that.

Ms Beauchamp: for national treatment services—

Senator DI NATALE: But there was only $40 million of additional money allocated in the 2017-18 budget?

Ms Beauchamp: Yes.

Senator DI NATALE: And, of that $40 million, only half of that was for frontline services?

Dr Studdert: You mean the 2018-19 budget?

Senator DI NATALE: Sorry, the 2018-19 budget—yes, correct.

CHAIR: Sorry, Ms Beauchamp, could you finish your answer? I was actually interested if you still had somewhere you were going with that.

Senator DI NATALE: There was a lot of—

Ms Beauchamp: I think I was saying that this is only a very small part of the overall allocation of Commonwealth dollars to drug and alcohol treatment services. In last year's budget, I think there was $561 million allocated for drug and alcohol treatment services across the country. That was dedicated for treatment services. Much of that went through Primary Health Networks to commission locally based treatment in line with community needs. I think part of that was built on the National Ice Action Strategy. Part of that was for Indigenous-specific services, treatment services—particularly residential rehab services. I guess that this is only an add-on to what's already a significant investment by the Commonwealth around drug and alcohol treatment services.

CHAIR: Thank you. Senator Di Natale?

Senator DI NATALE: Just to be clear, there was $40 million of additional funding in the 2018-19 budget—$20 million to professional development and another $20 million to services, that is, drug rehabilitation services.

Dr Studdert: That's correct.

Senator DI NATALE: And that $20 million, the only additional funding for services in the 2018-19 budget, was allocated to South Australia?

Dr Studdert: That's correct, but noting that we still have another two years of rollout of the National Ice Action Strategy through to mid-2020, in all jurisdictions.

Senator DI NATALE: I've got some questions around drug testing for income support recipients, but I suspect most of those will be dealt with tomorrow. Just a couple of questions that might be relevant—

Dr Studdert: Sorry, I think that would be for the Department of Social Services—

Senator DI NATALE: Yes, I was about to say that I suspect most of that will be for DSS, but—

Dr Studdert: Oh, okay.

Senator DI NATALE: But I think at the last estimates you told me that originally you thought you hadn't had a meeting with ANACAD, and then I think you came back and we got some revised evidence around that.

Dr Studdert: That's correct.

Senator DI NATALE: There's been a Senate inquiry since that time, and the overwhelming—in fact, almost unanimous—body of evidence from that inquiry was that it was a shocking idea. Have you advised against pursuing the trial based on the evidence that was disclosed during the Senate inquiry?

Mr Laffan: We haven't provided any advice to Social Services, and it was the Social Services people who gave advice at that inquiry.

Senator DI NATALE: I might move to something else. Because I've got Senator Smith here, perhaps we'll go to alcohol. I might start with a wonderful piece of writing in the *Australian Financial Review* dated 4 February 2018.

Senator WATT: What was that? I think that's a cheap shot there!

Senator DI NATALE: Senator Smith states—and I must say it was a very cogent piece:

Australia's alcohol taxation structure is devoid of any consistent set of principles. Its incoherency arises from disparate reforms introduced over many years.

I thought that was absolutely spot on. Senator Smith also noted the health consequences associated with the current alcohol taxation system.

Senator McKenzie: Is this a piece on Modest Members?

Senator DEAN SMITH: One of the 60, I think.

Senator McKenzie: There we go! I hope you subscribe to the others, Senator Di Natale.

Senator DI NATALE: Well, a broken clock is right every now and then. Then he goes on to say:

And with Australia's preventive health sector frequently calling for alcohol tax reform, given the social cost of alcohol misuse on our hospitals and health services, it's clear the current system is failing both our wine producers and our community.

Can I ask whether Senator Smith's wonderful piece of work submitted to the *Financial Review* is currently being considered and whether the government's doing any work specifically about possible changes to the taxation of alcohol, and specifically the wine equalisation tax?

Senator DEAN SMITH: I didn't put Senator Di Natale up to this, but I'm very curious.

Dr Studdert: Obviously I've missed something very special, but I would have to say that's a question for our Treasury colleagues.

Senator DI NATALE: Have you provided any recommendation in this respect to your Treasury colleagues?

Dr Studdert: No.

Senator DI NATALE: Have you done any work in this regard at all?

Dr Studdert: No.

CHAIR: Senator Di Natale, are you still on this topic?

Senator DI NATALE: I have a couple more.

Senator DEAN SMITH: I hope you take that line of questioning a bit further.

Senator DI NATALE: If I've got time I will.

CHAIR: Please do. We'll just throw the call back to Senator Watt, and then we'll come back to you.

Senator DI NATALE: I have some more alcohol questions.

CHAIR: But I want to point out to members of the committee that we are coming down to the point where we're going to start eating into outcome 3's time, which I'm sure Senator Farrell will be very disappointed with if we do, and we've still got a fair bit to go.

Senator WATT: We have culled questions that we've got for the remainder of outcome 2, but we still do have some.

CHAIR: Okay. Let's get to it.

Senator WATT: Minister, I'm an avid follower of your Twitter account.

Senator McKenzie: Thank you, Senator Watt, and I of yours.

Senator WATT: Thank you. I noticed that you spoke to ABC News on Sunday about World No Tobacco Day. That's this Thursday?

Senator McKenzie: The 31st.

Senator WATT: 31 May?

Senator McKenzie: Yes.

Senator WATT: Why is World No Tobacco Day important?

Senator McKenzie: Because we want to get down smoking rates, obviously. We lead the world in cessation of smoking. State and federal governments over decades have used a range of strategies to really bring down the smoking rates in the Australian population. But, as you'd be aware, our Indigenous Australians still have a very high rate of smoking, upwards of 40 per cent, which isn't good enough. So on the weekend, as part of the start of Reconciliation Week, I was in Alice Springs, and speaking there we had an Indigenous curtain-raiser to the inaugural Sir Douglas Nicholls rounds of the AFL, so there was a great opportunity to really target the messaging to Indigenous communities.

Senator WATT: And I think you launched it.

Senator McKenzie: We had an entire campaign around 'Don't make smokes your story', which is translated into 11 Indigenous languages. We're really targeting that cohort to hopefully bring down smoking rates in that community.

Senator WATT: Why is it so important that we get smoking rates down?

Senator McKenzie: Because cardiovascular disease kills; smoking is obviously a key factor in that. Every 12 minutes in Australia, one person has issues with that. So it's incredibly important for the health and wellbeing of our nation that we decrease—even though it is a legal substance in our community—the dependency on tobacco in the Australian public.

Senator WATT: Am I right that smoking is still the leading preventable cause of death in Australia?

Senator McKenzie: Yes, you're right.

Senator WATT: Particularly in Indigenous communities?

Senator McKenzie: That's right.

Senator WATT: Is the National Party still taking tobacco donations?

Senator McKenzie: As you know, like your party, the donations received are a matter for the party organisation and are publicly disclosed.

Senator WATT: No. Unlike my party, which stopped taking tobacco donations 14 years ago, and unlike the Liberal Party, which stopped taking donations from tobacco five years ago, your party continues to take donations from big tobacco?

Senator McKenzie: As I said, what donations are taken by the National Party are a matter for the party organisation, but I would like to state that—irrespective of who's giving money legally to the party organisation—it in no way deters my determination as the minister responsible to decrease tobacco consumption and smoking rates in this country.

Senator WATT: So you're the Deputy Leader of the National Party and you have no authority over your party about its decision to take donations from tobacco, despite everything you've just told us about how bad tobacco is?

Senator McKenzie: It is bad, and that's why I am committed—as is my department—and that's why we're investing the amount of money we are as a government and that I'm signing the briefs off that that money gets spent. Irrespective of what the political party organisation does or doesn't do with accepting donations from legal entities, it does not deter me in my desire to see smoking rates decrease in this country.

Senator WATT: You've got a phone there, you've got a computer there, you could email or you could text right away?

Senator McKenzie: I could bully my president?

Senator WATT: No, you could just ask them; you don't have to bully them. You could ask them, just like we did and just like the Liberal Party did.

Senator McKenzie: Senator Watt, donations—

Senator WATT: Why don't you exercise leadership?

Senator McKenzie: I'm happy to keep saying it: donations are a matter for the political party and the organisation.

Senator WATT: Which you are the deputy leader of?

CHAIR: This is well outside these estimates hearings parameters—

Senator WATT: No, it's not. It's about tobacco.

Senator McKenzie: Irrespective of the organisation donating to the Nationals, it doesn't deter my desire to see smoking rates decrease in this country.

Senator SINGH: Don't you think it's hypocritical?

Senator McKenzie: I don't feel conflicted, because everything I do is around decreasing smoking rates. I don't think we could do much more. We've launched the third phase of the Don't Make Smokes Your Story campaign on the weekend. We have campaigns going. We have partnerships with bodies like the AFL, with our states. We lead the world. We lead the world in decreasing smoking.

Senator SINGH: We don't deny your goodwill and the programs that you've put in place.

Senator McKenzie: Thank you.

Senator SINGH: But isn't it hypocritical that you are doing that, that you are putting these good programs in place on the one hand, and on the other hand you and your party are taking money from big tobacco?

Senator McKenzie: Well, I'm not taking any money from any cigarette company, Senator Singh. It's a matter of public record who donates to the National Party, and it is a matter for the organisation.

Senator WATT: But—

CHAIR: You've had your chance to ask those questions.

Senator WATT: On Sunday you were out there telling the world, 'I care about smoking. Don't smoke. It's terrible for you,' and on Monday your own party is taking donations from tobacco companies? You don't see any hypocrisy in that?

CHAIR: Please don't answer that question, Minister. Estimates hearings are not an appropriate venue to discuss the activities of the National Party. You've asked the minister—

Senator McKenzie: You can come to my next—

Senator WATT: I would have thought—

CHAIR: You have asked the minister five times; she's answered it very clearly; let's move on.

Senator WATT: Maybe by the next estimates, she could show some leadership and suggest that her party stop taking tobacco donations, just like the Liberal Party has stopped—the Greens maybe never took them—and like we stopped doing a long, long time ago.

Senator DI NATALE: I'm happy if Senator Watt wants to continue that line of questioning!

Senator McKenzie: Rinse, repeat!

Senator DI NATALE: Just some more questions on alcohol. Could you provide us with an update on the status of the funding for the Women Want to Know and Pregnant Pause campaigns around alcohol?

Dr Studdert: I'm just checking if we have that information at hand.

Mr Laffan: I'd need to take questions about those two on notice.

Senator DI NATALE: So you can't tell me if funding for both of those health programs is going to continue beyond 2018-19?

Mr Laffan: I'm not sure if it is. I don't have that information in front of me.

Senator DI NATALE: If you don't mind taking that on notice?

Mr Laffan: Sure.

Senator DI NATALE: Can I ask you about the status of Drinkwise? Obviously you know about Drinkwise—an industry body that provides so-called information to people. Does the government provide any support or funding to Drinkwise?

Mr Laffan: No, we don't.

Dr Studdert: Not at this time.

Senator DI NATALE: Can the department confirm whether any support has been provided for the industry or for Drinkwise to develop its own consumer health information around alcohol and pregnancy to be provided to health professionals?

Mr Laffan: We have not provided any funding to Drinkwise.

Senator DI NATALE: Any other support?

Mr Laffan: No.

Senator DI NATALE: You're not in any discussions with Drinkwise around this?

Dr Studdert: No.

Mr Laffan: No, we aren't.

Senator DI NATALE: So there's no preference given to industry programs that are obviously funded through Drinkwise as opposed to other programs like the two I've just mentioned?

Mr Laffan: Drinkwise are an independent organisation that run their own program.

Senator DI NATALE: Some might argue about that. Can I go to the question of obesity and ask specifically about any measures in the budget that are designed to combat or address obesity.

Dr Studdert: You'll be aware that in the budget there was a package of measures around healthy active beginnings for infants and pregnant women.

Senator DI NATALE: Yes.

Dr Studdert: That did include some measures that relate to healthy weight and physical activity during pregnancy. My colleague can tell you a bit more about those.

Senator DI NATALE: That's specifically about pregnancy, yes?

Dr Studdert: That's one of the areas in the life cycle where we know there is a risk of weight gain.

Senator DI NATALE: Sure. Because we do have limited time, can I ask beyond Healthy Beginnings. Can you list any other—

Dr Studdert: There was also a major package of measure around physical activity promotion, working with the Australian Sports Commission. We continue a range of measures in the food space—health star rating, Healthy Food Partnership, Australian dietary—

Senator DI NATALE: Let's go through those. With the health star rating, what in particular?

Dr Studdert: That's the rollout of the health star rating system on food products in groceries, which I'm sure you are familiar with.

Senator DI NATALE: I'm familiar with it, but what about specifically in this budget? There is just some ongoing funding for the rollout, yes?

Dr Studdert: Yes, but that is a significant commitment that's ongoing with the states and territories.

Senator DI NATALE: Is it still voluntary?

Dr Studdert: It's still voluntary but rapidly being taken up by manufacturers. Over 10,000 products are now carrying that.

Senator DI NATALE: So you've mentioned—

Senator McKenzie: We've got $30 million going to physical activity community infrastructure to overcome some of those barriers. With supporting activity in old Australians, we've got $22 million, nearly $23 million, there.

Senator DI NATALE: What's specifically around that?

Senator McKenzie: That is going to be working with sporting organisations to keep Australians active as they age, similar to FFA's walking soccer program et cetera to keep them physically active. We've also got an amount of money, I think it's $22 million, for community participation grants, which are going to be specifically targeted to inactive cohorts in our communities.

Senator DI NATALE: I might put some more questions around that on notice. I'm good.

Dr Studdert: Could I just add something to the discussions we had with Senator Urquhart about the local drug action teams?

CHAIR: Certainly.

Dr Studdert: I have received clarification that when a local drug action team has developed its plan it can come forward at any point in time to get the rest of the funding. It doesn't have to wait for that six-month cycle.

Senator URQUHART: There's no round.

Dr Studdert: The six months was the period of time we've done between rounds of identifying areas where the local drug action teams will be rolled out, but the follow-up and the funding of those plans, when they're developed, can happen at any time.

Senator URQUHART: So they've got the $10,000 through their plans, and then they have the opportunity at that stage to come forward.

Dr Studdert: Yes, and that can be done at any time when they need it.

Senator URQUHART: Great. Thank you.

Food Standards Australia New Zealand

[20:45]

Senator RICE: I want to continue a line of questioning that I asked at previous estimates—I cannot remember whether it was the last one or the one before that—about the presence of nanohydroxyapatite in baby formula given the concerns about nanohydroxyapatite being potentially toxic based on a study by the European Union Scientific Committee on Scientific Safety. At estimates in February you indicated that the statement on your website that nanohydroxyapatite was prohibited in infant formula was an error and you indicated as well that nanohydroxyapatite was a synonym for other chemicals that were permitted. I will read out exactly what the Hansard says. You said:

Essentially, we did initially put out advice that that was not permitted under the Food standards code. However, we very quickly realised after doing some further checks with the codex chemicals area that there are a number of synonyms for that particular chemical or a number of names. We very quickly recognise that the name 'hydroxyapatite' was a synonym for other chemicals which were permitted, so it was actually permitted. So it was a slight error on our part to say initially that it wasn't all the time; it was.

Do you still stand by that evidence?

Mr Booth: Yes, that's correct.

Senator RICE: Therefore, nanohydroxyapatite is permitted in baby formula?

Mr Booth: Yes. The explanation given last time was correct: it is a synonym.

Senator RICE: Did you mean by 'synonymous' that nanohydroxyapatite, as a calcium phosphate compound, has the same chemical structure as a permitted form of calcium phosphate in baby formula?

Mr Booth: That is quite a complex question. I'll have to take that notice and get an answer from our scientist.

Senator RICE: Are you aware that in May 2016 your staff indicated that there are three permitted forms of calcium in phosphate and that they are not the same as nanohydroxyapatite?

Mr Booth: Again, I do not have that information in front of me. My colleague Mr May may have something to add.

Mr May: There are three forms of calcium phosphate compounds that are permitted—monobasic, dibasic and tribasic. There are many other forms of those compounds. What is unclear in this is what was being found by the tests that were being done. Nanohydroxyapatite, at one level, is a very complex form of calcium phosphate compound—not monobasic, dibasic or tribasic. But what we then discovered was that, in some places, the monobasic, dibasic and tribasic forms are referred to as hydroxyapatite. And that was the clarification we issued: yes, some forms of things that some people will call hydroxyapatite—not nanohydroxyapatite but hydroxyapatite generally—which might be formed in a nano form are permitted but the other forms are not permitted forms for the purpose of the code. The presence of those forms of the phosphate compounds doesn't make them illegal; it just means that they have not been approved for use in those foods.

Senator RICE: But the evidence that was given was that nanohydroxyapatite, the chemical assessed by the European scientific committee, was permitted. And Mr Booth has just said that it is still permitted.

Mr May: What is permitted is the monobasic, dibasic and tribasic forms of those compounds, which may well be in nano form because all of those compounds can exist in nano form or non-nano form.

Senator RICE: So they are different chemicals. The information I have here is that hydroxyapatite has a different identifier on the Chemical Abstract Service's numbers. They are quite separately identified chemicals.

Mr May: I think that's exactly the point that we were making. When we first looked at the issue, what we identified was that hydroxyapatite was generally known or specifically known as quite a complex compound. I don't know how you would describe it, but, from memory, it's got five calcium and 10 or 12 of the phosphate molecules. That's why initially we said that hydroxyapatite isn't one of the permitted forms. Then we realised that, in fact, what is permitted—that is, the monobasic, dibasic and tribasic forms—is also referred to in general parlance, not scientific parlance, as hydroxyapatite. So, to clarify the issue, that further statement was provided.

Senator RICE: I think what we're particularly talking about is the scientific definition of them and not in common parlance.

Mr May: Yes, but what's not clear in the study is exactly what form of the compounds was being identified. At no stage have I seen any document that says what form the calcium phosphate compounds existed in in the materials that were found.

Senator RICE: So you're saying that the European study that identified them as being potentially toxic—

Mr May: Sorry. Are we talking about the same studies? There was a European study that was looking at cosmetics. There was another study that was done for Friends of the Earth,

which identified hydroxyapatite in infant formula; but the European study wasn't finding hydroxyapatite.

Senator RICE: The European study led it to recommend that nano-hydroxyapatite should not be permitted in oral products, because it was potentially toxic.

Mr May: That's right.

Senator RICE: So you are saying that that study wasn't specific as to whether it was what form of hydroxyapatite—

Mr May: I'm not saying anything about that particular issue, because that doesn't relate to food at all.

Dr Crerar: That study was not considered applicable to ingestion. It was found to be wanting in terms of its appropriateness for food purposes.

Senator RICE: That study was recommending that it not be used at any level in mouthwash and toothpaste at that stage, because it was, in their words, potentially toxic.

Mr May: That's right. It was about topical use of the particular products containing that compound.

Senator RICE: There are the emails from your staff that have been referred to me. You have staff that said that the nano-hydroxyapatite was not permitted. I'm quoting Ms Gillian Duffy, a senior nutritionist at Public Health Nutrition Standards.

Mr May: That's right. It's not one of the permitted forms. I think we've got to be very clear about what 'not being a permitted form' means. It's a form of the compound that has not been specifically permitted for use, but that doesn't mean that the use of any other form of that compound is illegal. What has to be satisfied in relation to any other form of that compound is whether or not it's safe or suitable—and that's a different question.

Senator RICE: But you were saying that that form, the nano-hydroxyapatite—that isn't calcium phosphate tribasic, dibasic or monobasic—is not permitted?

Mr May: The code makes no distinction between nano forms and non-nano forms. What the code says is that for the purpose of those particular products, the infant formula products, certain forms of calcium phosphate or, in this case, certain forms of calcium and certain forms of phosphate can be present in the calcium phosphate compounds in those particular formats but not in other formats. It makes no distinction as to whether or not those formats constitute nano forms or non-nano forms.

Senator RICE: Whether they are nano forms or not, you've got four different chemicals—

Mr May: We've got potentially more than four.

Senator RICE: That's right, but they are different chemicals. They have different numbers and chemical abstracts. You have hydroxyapatite, calcium phosphate tribasic, calcium phosphate dibasic and calcium phosphate monobasic. The latter three are permitted but the hydroxyapatite is not permitted.

Mr May: The other calcium phosphate compounds have not been specifically referred to as permitted forms.

Senator RICE: How do you then say that, in fact, they are permitted? Mr Booth's evidence before was that they were in fact permitted.

Mr May: This goes back to the point that I made initially that, in general parlance, hydroxyapatite is recognised as a—

Senator RICE: But I'm not talking about general parlance. I'm talking about the scientific definition of that chemical.

Mr May: Indeed, Senator. And to some extent we would say that we answered the question correctly the first time when we said that it's not a permitted form, because, if hydroxyapatite is only understood as being the complex phosphate compound, then it's not permitted. If we understand that hydroxyapatite can be and is referred to in some places as any one of those calcium phosphate compounds, then a broader brush has to be drawn.

Senator RICE: And those latter three—

Mr May: And the distinction, we would say, is that it's only the first three forms that are permitted. Any other form is not permitted. But not being permitted doesn't mean that that compound cannot be present. It might be present for a whole range of reasons, including simply a natural presence. And a natural presence isn't prohibited.

Senator RICE: No, but, if it has indeed been added as nanoparticles, as nanohydroxyapatite but not one of the other forms, that is not permitted—

Mr May: That's exactly right.

Senator RICE: in baby formula.

Mr May: Yes, we agree on that.

Senator RICE: Thank you. I'm glad I've been able to clarify that.

CHAIR: Now I'm totally confused! As we have no further questions on that, you go with our thanks. We can also release people from program 2.4 insofar as they are not required for later programs.

[20:56]

CHAIR: We'll move on to program 2.5, Primary health care quality and coordination.

Ms Beauchamp: Excuse me, Chair. There is just a clarification from one of the officers.

Dr Studdert: I just have a clarification from the questioning before by Senator Di Natale about DrinkWise. Just to be clear: my history boffins have informed me that there were in the past two amounts of money provided to DrinkWise, one in 2005-06 for a campaign around alcohol education, Kids Absorb Your Drinking; and, in 2012, $600,000 for point-of-sale education material to highlight the message that it's safer not to drink while pregnant.

Senator DI NATALE: That's historical?

Dr Studdert: That's historical—absolutely nothing at the present.

Senator DI NATALE: Thank you.

Senator SINGH: I want to ask about the Health Care Homes program. The Prime Minister said the government's Health Care Homes program would 'revolutionise' care and described it as 'one of the biggest health system reforms since the introduction of Medicare 30 years ago'. Is that still the view of government?

Ms Edwards: Health Care Homes is a trial program that we're continuing to roll out.

Senator SINGH: Minister, can I ask you then? Would you like me to repeat the Prime Minister's quote?

Senator McKenzie: Stage 1 of the government's trial announced in 2017 will cease on 30 November. I think we're running the trial.

Senator SINGH: So it's not the biggest health system reform since the introduction of Medicare 30 years ago?

Senator McKenzie: I'm the Minister for Rural Health, so I'd be saying that the $550 million investment into the Rural Health Workforce Strategy announced in this budget is the most transformational thing we've done of late, but I think each one of us in cabinet—

Senator SINGH: So you don't agree with the Prime Minister?

Senator McKenzie: I think each of the health ministers has a strongly held view on what the key components of our government's health reform agenda are. This was one of them. The Prime Minister's—

Senator SINGH: Sorry?

Senator McKenzie: I'm not ignoring what the Prime Minister said. If that's what he said, that's what he said.

Senator SINGH: The question was: is it still the government's view?

Senator McKenzie: I'm not sure the Prime Minister was expressing the government's view. He was expressing his view and not prioritising this particular initiative over other initiatives of reform that our government's undertaken across the Health portfolio.

Senator SINGH: So you're confirming that it was his view, not the government's view?

Senator McKenzie: Well, as I said, I'm the rural health minister, and what I would say is the most transformational reform we've made in government in the Health portfolio would be the $550 million investment into the Rural Health Workforce Strategy. I think every minister and cabinet minister has a view on what they see as the priority of reform measures we've undertaken.

Senator WATT: The Prime Minister's view doesn't count more than anyone else's?

Senator McKenzie: I think every minister has their own view on what they think are the priorities. I've told you what I think is the most transformational reform we've made in the health space. I'm sure Minister Hunt has his view on what the most transformational reform measure we've done is—

Senator WATT: He might agree with the Prime Minister.

Senator McKenzie: and the PM might have a different view. We are allowed to have different views on the priority measures. The thing is that we all back our joint venture.

Senator SINGH: Interesting. Did you just say that this trial has come to an end?

Senator McKenzie: No, I didn't say it's come to an end. It's ending, I think, in 2019.

Ms Beauchamp: 30 November 2019.

Senator SINGH: It was supposed to involve 200 medical practices. How many are participating now?

Ms Edwards: As at 16 May, 171 practices were participating.

Senator SINGH: It was supposed to enrol 65,000 patients. How many are enrolled right now?

Ms Edwards: It was supposed to enrol up to 65,000 as a maximum amount.

Senator SINGH: Sorry. Right.

Ms Edwards: At the moment, or as at 16 May, there were a little under 2,000 patients enrolled.

Senator SINGH: Sorry, 2,800?

Ms Edwards: A little under 2,000.

Senator SINGH: That's around three per cent—from my maths—of what the government projected.

Ms Beauchamp: It is a trial which is operating until 30 November. It's taken some time for the practices to register, and the uptake probably has been slower than we've expected, but it's still a long way to go in terms of the trial. In terms of the principle around integrated home care—

Senator SINGH: A 'little bit'? A 'little bit' slow, Ms Beauchamp? It's three per cent!

Ms Beauchamp: In terms of an integrated package of support around chronic conditions, we're looking at what feedback we're getting from the practices in terms of making improvements to the Health Care Homes trial.

Senator SINGH: This is three per cent of what the government projected. Doesn't that show that this trial has been a total failure?

Ms Edwards: This trial, Health Care Homes, is trying some really important new ideas about how we really stretch our thinking about primary care, how we do innovations in primary care, how we work with practices to do things differently. The take-up has been lower than we had hoped for, and that's something we're looking at in itself because we want to make sure we get real value out of what we've done so far so we can evaluate it and then build on what happened.

Making real changes and reforms in this space means we have to try new things, and that's what we're doing. We're learning from it as we go. In some pockets there's been really good take-up by particular practices who are telling us very interesting things on a small scale. That's not what we had anticipated in terms of numbers at this stage, but we're still building up the numbers and working with practices and PHNs so it will have sufficient patient numbers to really robustly evaluate what's gone on and then build so we can do further reforms and really grow what we're doing in primary care.

Senator SINGH: No wonder Minister McKenzie is not endorsing the Prime Minister's quote that this is the biggest health system reform since the introduction of Medicare!

Senator McKenzie: It's a trial, so let's try it.

Senator SINGH: On Friday, the minister told the AMA National Conference that he was working with the profession on the lessons from Health Care Homes. I know there's going to be some formal evaluation out of this, but what do you think the lessons are at this stage?

Ms Edwards: I think we need to wait for the formal evaluation to really get a sense. But we've certainly learned in the implementation that some of these things are hard to do, and

some of the things we had hoped to do as a department didn't work out as quickly or as easily as we had thought. That's important learning about the way practices are worked up, about the sorts of supports they need to take on new approaches. So there have been a lot of important learnings there for us that we're using as we go along both in continuing to roll out Health Care Homes and as we think about what the next wave of reform for primary care might be. This is an ongoing, difficult and important area that we are committed to and which the government has asked us to work on, and that is what we are continuing to do.

Senator SINGH: At the AMA national conference the minister also hinted at some changes to the model, as you would probably expect. Is the government actually walking away from Health Care Homes?

Ms Edwards: I'm not aware of any change. We're continuing to roll out. We're looking at ways that we can help our supported practices to increase the patient numbers. We're doing that as a department. As far as I'm aware, the trial is continuing. It will be evaluated in due course and we'll take learnings from it.

Ms Beauchamp: As you said, Senator, I think an interim evaluation is being made in early 2019. The minister, Minister Hunt, has said that we need to work closely with the Royal Australian College of General Practitioners and the AMA to get a practitioner perspective and, obviously, getting a consumer perspective on how we make this work in the longer term.

Senator SINGH: Why is the minister talking about a new model for this health care program already, when only less than halfway through the program?

Ms Beauchamp: I think he's talking about a model that has the principles around Health Care Homes that meets the needs of practitioners and consumers?

Senator SINGH: Isn't he talking about a new model, because this program has been a total failure?

Ms Beauchamp: I think he is waiting for and wants to work closely with the professions and consumers to see what elements of the model need to be improved and strengthened.

Senator SINGH: Minister, did you not endorse the Prime Minister's comment that this is the biggest health system reform since Medicare, because you know as well that this is a total failure?

Senator McKenzie: No, it is not that I don't endorse it. You're asking me if I thought it was the most important thing we've done.

Senator SINGH: Have you endorsed his quote?

Senator McKenzie: If that's what the PM thinks, then, fantastic. But, as rural health minister, I think the most transformational reform we've made in health for the communities and people I represent is the Rural Workforce Strategy handed down at the last budget.

Senator SINGH: Do you think Health Care Homes—

Senator McKenzie: I think this is equally—

Senator SINGH: Do you think Health Care Homes has been a total failure?

Senator McKenzie: No, I don't, at all. I understand trial and error. I understand you have to trial things. It is an iterative process. You get feedback throughout. You modify and adapt and learn new things. We didn't roll this out across the country from day 1. We thought, 'This

is a new idea. It is a worthy idea. Let's see how it goes,' and work to work it up into a program that we can roll out throughout the nation. Clearly, it's providing some lessons early on. The interim evaluation will be done in early 2019, and obviously we'll have more to say about it after that.

Senator DI NATALE: Health Care Homes is really the bulk of my questions. Perhaps I'll just ask a couple of questions around medicinal cannabis training for primary care. Is that something the department might be able to help out with? I understand that the first free training for doctors in Canberra on medicinal cannabis took place last week. Is that something the department is aware of?

Ms Beauchamp: I will just make sure we have the relevant officers here.

Senator DI NATALE: I have a few questions on the Health Care Homes trial, which I can put on notice.

Ms Beauchamp: The medicinal cannabis people aren't here. They are coming tomorrow.

Senator DI NATALE: This is more about the training component.

Ms Beauchamp: Yes.

Senator DI NATALE: I know some training in Canberra for doctors occurred at the end of last week. The department is not aware of that?

Prof. Murphy: I think that's probably all under the whole TGA program, so I think it's probably addressed under outcome 5.

Senator DI NATALE: I'll ask them but I suspect that if you guys don't know about it the TGA won't know about it, because it's training for GPs—

Ms Beauchamp: I'll find out overnight—

Senator DI NATALE: Take it on notice—

Ms Beauchamp: and commit to providing information tomorrow.

Senator DI NATALE: I will go to a couple of questions around Health Care Homes. Do you have specific criteria that you're using to evaluate the trial? If so, what are they? What are the specific indicators that you're using for your evaluation?

Ms Edwards: Ms Quigley might be able help us out with the details of the evaluation plan.

Ms Quigley: The evaluation is predominantly focused on the implementation perspectives of the trial. So it will include things like what it has taken for practices to take on the model—what sorts of system processes they've taken on board; what sorts of models of care they are using to support their patients. We'll be looking at the risk stratification tool—

Senator DI NATALE: What about outcome measures?

Ms Quigley: As to outcomes, because this is for a period of two years, we will be using patient experience and outcome measures, but we recognise that, within that time frame, it's going to be quite difficult to measure outcomes, which is why we're focused significantly on the implementation aspects.

Senator DI NATALE: But things like glucose control—outcome measures like that?

Ms Quigley: Because the trial is disease agnostic—so we're looking at complex and chronic disease more broadly—we haven't got specific clinical markers, but we will be looking at the patient's profile when they started in the trial and then—

Senator DI NATALE: Specifically—like what?

Ms Quigley: The patient is likely to have two or more chronic diseases. They could include a range of things—

Senator DI NATALE: Let's assume diabetes and heart disease.

Ms Quigley: So you'd be looking at the clinical markers as far as their HbA1c is concerned—

Senator DI NATALE: Sorry—I thought you said you weren't looking at clinical markers?

Ms Quigley: But that information will be collected as far as their patient profile. So you will be able to understand the patient's journey. But, again, experience and outcomes, we recognise, are going to be difficult to measure within that two-year period.

Senator DI NATALE: So are we or are we not collecting biochemical markers and monitoring them over time?

Ms Quigley: Not specifically, no.

Senator DI NATALE: So we're not doing HbA1c, for example, to monitor that over time?

Ms Quigley: The practice will be collecting that information, clearly, as a part of their management of a patient's—

Senator DI NATALE: Yes, but I'm talking about evaluation. Of course if they've got a diabetic they'll be checking the HbA1c. I'm talking about the evaluation. Do you have specific indicators that look at biochemical markers—like HbA1c, for example; like people's lipids—to assess the specific outcomes associated with the trial?

Ms Quigley: There will be information that's collected around the patient outcomes—

Senator DI NATALE: Such as? What information?

Ms Quigley: Well, it'll be the clinical indicators that are linked to the person's individual case. Again, because we're not focusing on particular aspects of particular diseases, and it's disease agnostic, we haven't said we'll be measuring HbA1c or other—

Ms Edwards: I think Ms Quigley was saying that we're looking at the implementation, and all the implementation, because that's what the focus of the evaluation is. While information about the clinical information about particular patients will be collected by practices and will be relevant, perhaps on an anecdotal or case by case basis, we won't have, necessarily, a particular cohort of one particular group of patients who will all have the same clinical markers with which to compare—

Senator DI NATALE: I'm not asking that. When you do an evaluation, it's really straightforward. You have clear indicators: 'This is the information we're collecting to see if the program worked. Here are some outcome indicators to see if the program worked.' What are those outcome indicators?

Ms Edwards: Because there won't be a single condition affecting a large cohort of patients, we won't be collecting that data as the evaluation, because it won't be comparable across the group. We'll be focusing on implementation evaluation.

Senator DI NATALE: You're saying that, as to something like diabetes, you're not going to be able to get information about glucose control in a patient cohort with chronic disease?

Ms Edwards: We're saying that we are not requiring practices to have a certain number of diabetic patients and therefore to be able to evaluate—

Senator DI NATALE: How are you going to evaluate it? How will you know if it works?

Ms Edwards: The initial evaluation over the first two-year period will be focusing on the implementation aspects to see what has happened in the practices with their patient care.

Senator DI NATALE: But that doesn't tell you anything about whether you want to put your dough into it.

Ms Edwards: It tells us—

Senator DI NATALE: It doesn't tell you whether it's a government program that a future government wants to invest in.

Ms Edwards: It tells us some things in the initial period. It doesn't tell us everything, because, as Ms Quigley said, it's over a reasonably short period. We're finding what we can in that initial period and will evaluate what we can.

Senator DI NATALE: Government is faced with a choice about investing money in a program like this because it's going to deliver better outcomes; you want to measure whether it's actually delivering better outcomes. Do you have an evaluation framework for this project?

Ms Quigley: Yes, it's available on our website.

Senator DI NATALE: What are the outcome indicators associated with that framework?

Ms Quigley: If you're happy for me to, I'll get the plan and outline the range of approaches that is in there—

Senator DI NATALE: Not approaches—the specific indicators that you're measuring.

Ms Quigley: And the specific outcomes, yes.

Senator DI NATALE: Okay. Perhaps you can take that on notice.

Ms Edwards: Yes.

Senator DI NATALE: That would be helpful. Did you have specific targets for take-up by a particular time?

Ms Quigley: No, we didn't have targets. The expectation was that the first 12 months of the trial would be used for patient enrolment. That will allow a full year's worth of clinical service delivery for all of the patients enrolled.

Senator DI NATALE: So you didn't have a target for uptake by a particular time?

CHAIR: Senator Di Natale, are you going to able to finish up in the next few minutes?

Senator DI NATALE: Yes, I can. Very quickly, do you have the mix in terms of the patients that are enrolled in corporate practices—Sonic primary practices et cetera—versus other practices?

Ms Quigley: We have a break-up of the practice size, shape, geographic region et cetera.

Senator DI NATALE: If you could provide that on notice. Can you tell me how much the department spent on the rollout, including consultancies and staffing, in 2016-17 and 2017-18?

Ms Quigley: Yes.

Senator DI NATALE: Do you have that figure now?

Ms Quigley: For 2016-17, it's $7.8 million. For 2017-18, it's $21.6 million.

Senator DI NATALE: What's that for?

Ms Quigley: That's for a range of clinical services that will be provided to the patient, but it also covers things like the development of the risk stratification tool; and the evaluation, education and guidance funding to PHNs to support on the ground. So it's for a range of infrastructure kinds of supports, but there is also a clinical spend.

Senator DI NATALE: Okay. Finally, are there any lessons that you might want to share at this stage about the rollout of the trial?

Ms Edwards: Other than in our responses to previous questions?

Senator DI NATALE: Yes.

Ms Edwards: We're continuing to learn how important it is to look at primary care, how difficult it is to change major systems like this, and how some practices take up and really run with things and others find it very difficult to adopt new practices. It is very early on, and that's why we have a consortium to do an evaluation of how this is rolling out—and we're looking forward to those lessons. But we're monitoring it closely and listening to what stakeholders, participating practitioners and our expert advisory groups tell us.

CHAIR: On that note, we will have a short suspension. We've gone slightly overtime. We will resume around 9.35 pm.

Proceedings suspended from 21:18 to 21:33

CHAIR: Ready to go? Okay.

Ms Edwards: Chair, could I just add some information to the exchange we had with Senator Di Natale just before the break, on the evaluation of Health Care Homes?

CHAIR: Certainly. Go ahead.

Ms Edwards: It was just to clarify that, although specific, very micro indicators will be collected, those aren't the aim of the evaluation, as I mentioned. The types of things that will be covered in the evaluation are how the stage 1 rollout affects the quality of care and experience of patients with chronic and complex conditions; the experience of practices of Health Care Homes, including changes to the scope of practice, quality improvement system development, models of care, service delivery and business models; the use of health services by patients, particularly potential preventable hospitalisations, which is obviously something that can apply across all of the various patient types, regardless of condition, whether they end up in hospital or not; and the cost of care for government providers and patients. Those are the sorts of items that the evaluation will be directed to.

CHAIR: A follow-up question: what was the time frame of the trial?

Ms Edwards: The trial is due to run until November, 2019.

CHAIR: From beginning to end, is it two years?

Ms Edwards: It began in October last year.

CHAIR: So, 18 months, two years?

Ms Edwards: It is a two-year trial.

CHAIR: Clinical indicators wouldn't actually demonstrate very much over that sort of time frame anyway, would they?

Ms Edwards: They might not. And, also, because you'll have a range of people with different conditions, maybe there will be few or no indicators that actually apply to all patients or to a significant cohort of patients.

Ms Beauchamp: And a proper evaluation would require control groups and the like. Of course we're monitoring but if you want a full-blown evaluation that's not going to happen because you haven't got the proper evaluation prerequisites and control groups.

CHAIR: So it is more looking at the model of care rather than individual—

Ms Edwards: What impact this way of structuring care has on the type of care patients get?

CHAIR: Okay. We're still in program 2.5. Senator Watt.

Senator WATT: I have some questions about grants from Primary Health Networks.

CHAIR: Was that 'from'?

Senator WATT: Yes—from or by. Whichever word you'd like to use.

Senator McKenzie: By.

Senator WATT: I think 'by'. Is it the case that the North Queensland Primary Health Network delivered a grant to help establish a community pharmacy in Yarrabah, outside Cairns?

Ms Edwards: Grants are made by the PHNs as independent bodies. We haven't got visibility over the detail of those. I, and I think the officers at the table, am not aware of any such grant. We wouldn't expect to be, though. Our job is to prepare the guidelines and rules under which the PHNs operate and commission services. Details of particular grants would be a matter for the PHNs.

Senator WATT: The department does not have any oversight on any PHN grants that are provided?

Ms Edwards: Not specifically, no. They're a matter for the PHN—I beg your pardon; I stand corrected.

Ms Cole: We have awareness of the actual service providers who have been commissioned by the PHNs. There are close to 3,000 of those, currently. In terms of the individual details of the individual grants, we would have to take it on notice. However, in this particular case, we're not aware of a specific grant being made to establish a community pharmacy in that district.

Senator WATT: Would it be possible overnight or early in the morning to look into that a little bit further? I'm just wondering how you want to handle this, Chair, because, depending on the answer to that question, I might have more questions arising about a particular grant.

But I'm not sure if there's a lot of point in pursuing them now if we can't get confirmation on that grant.

Ms Edwards: We can make contact with the PHN.

CHAIR: Unless you want to put them on notice.

Senator WATT: Would it be possible to revisit this in the morning once we've been able to confirm—

CHAIR: Not once we move on. We can't recall.

Ms Beauchamp: Why don't we take it on notice and ask specifically what grants have been provided by that PHN—a list?

Senator WATT: And for what purpose?

Ms Beauchamp: Yes.

Senator WATT: Okay. Over, say, the last three years? How long have they been up and running?

Ms Cole: It's about three years now. It will probably be the last 18 months that will be relevant.

Senator WATT: Okay. Let's say two years then.

Ms Cole: Yes.

Senator WATT: Is the department aware of any concerns over the last couple of years regarding the governance of the North Queensland PHN, and particularly its board?

Ms Edwards: Yes, there have been some issues in relation to the North Queensland PHN—in relation to the composition of its membership, and also the flow-on that that had for the board. There's been some changes made to the governance of the North Queensland PHN over recent months. There was an issue with a finding of the Queensland Audit Office that the PHN in North Queensland was effectively a Queensland body, because of its membership, which is obviously not what we had anticipated for an independent PHN. Since that time, the PHN has made reforms which have included additional members which have changed the relative composition of the PHN in such a way as we understand that issue to have been resolved. It has also gone on to have a major changeover of board members, recently, which has also changed some of the issues that had arisen in relation to control of the board, and we're watching carefully to see how the governance arrangements settle in.

Senator WATT: I think you'd be aware that there are some guidelines that apply to the grants issued by Primary Health Networks, and they, among other things, contain clauses about managing conflicts of interest between board members, staff of the PHNs and grant recipients. If you don't have much visibility over the grants that PHNs are issuing, how can you be confident that those conflict-of-interest guidelines are being observed?

Ms Edwards: As Ms Cole corrected me, we do have some visibility with what grants are made, but they are decisions for the PHNs, and the PHNs are required to comply with the guidelines set by the department in its processes. So that's something we'd have regard to, in relation to its operations, our oversight and funding role, and required under the funding agreement to apply the relevant guidelines. So we effectively set the framework for

commissioning—something which we're closely watching and revising over time—so that the PHNs are making independent, robust decisions within the framework set by the government.

Senator WATT: Just on the matter of the governance of this particular PHN: I don't know whether you saw it, but there was an article on 22 November 2017 in the *Cairns Post* which talked about the resignation of the chair of the PHN, Mr Trent Twomey, who, among many other roles, has been the campaign manager for the member for Leichhardt. This article says: 'NQPHN board members yesterday told how similar concerns'—similar to concerns about his other role at Advance Cairns—'about his personality, pet projects and other issues led to a vote against him retaining the position as chair.' Has the department looked into these concerns at all?

Ms Edwards: The department has been working closely with the North Queensland PHN to ensure that the governance issues are resolved, and my colleagues would have more details of that engagement. That's something we've watched closely. As I say, there's been a significant change in membership of the PHN and also membership of the board over recent months.

Senator WATT: What steps have been taken to look into concerns about, particularly, the chair's conduct?

Ms Cole: We haven't looked specifically at the chair's conduct in the way that's described in that paper. We were more concerned around the issue around control of the PHN, by virtue of the structure of the membership and so forth, and that led to a number of constitutional changes, which included, for example, moving from some members of the boards being organisational representatives, and therefore becoming a board member, to a board which is much more an independent skills-based board, which we believe, in the long term, will be to the benefit of that PHN. The other thing is that we do have a current complaint, which we're investigating, in relation to that PHN, which is more around some other issues concerning a communication or a commissioning decision.

Senator WATT: What's the nature of that complaint?

Ms Cole: I don't think it's appropriate for me to say, except that it was in relation to a commissioning decision.

Senator WATT: A commissioning decision?

Ms Cole: Yes.

Senator WATT: By that PHN?

Ms Cole: Yes.

Senator WATT: Commissioning services?

Ms Cole: Yes.

Senator WATT: Does that involve grants as well?

Ms Cole: Essentially, it's the same thing. When a commissioning decision is made, it's usually followed up by a service contract between the PHN and whoever has been successful. So you could see that as similar to a grant given by the government. It's a service contract.

Senator WATT: Okay. That's a complaint that has been made—

Ms Cole: By an unsuccessful applicant.

Senator WATT: by an unsuccessful applicant about a decision that was taken while Mr Twomey was the chair of the PHN?

Ms Cole: That's correct.

Senator WATT: Yes. I would have liked to have pursued the issue of that particular grant further and—I'm not having a go here—that's why I gave notice that I was keen to do so and asked that we had the information required about grants approved and distributed by boards. I understand that, once we move on from this outcome, the opportunity is lost, but that was why I wrote that letter—so we'd be able to explore it here. Is there any opportunity to explore just that issue in the morning, given advance notice was provided?

CHAIR: No.

Senator DEAN SMITH: No. We don't want to set a precedent.

CHAIR: Once we move on, we move on.

Senator DEAN SMITH: You might remember, at the last estimates, we were very generous to Senator O'Neill and she abused that opportunity in the whole-of-portfolio section.

Senator O'Neill interjecting—

Senator WATT: I don't remember that, actually.

Senator DEAN SMITH: I do remember it, clearly. It's on the *Hansard*.

Senator WATT: Okay.

CHAIR: Perhaps, Ms Beauchamp, as you will be here in the morning, you might bring back any further information that will assist Senator Watt. But I don't think we can revisit the outcome.

Ms Beauchamp: As I said, I'd take on that information. But the fact that there is a complaint—I will also investigate what we can provide through the minister, in terms of responding to a complaint.

CHAIR: And, Senator Watt, given that clearly the department doesn't have the level of transparency on the issue that you want, I'm not sure why recalling them is going to help.

Senator WATT: I just would hope that, if there's a lot of money sloshing around in PHNs, there is some level of accountability, and I'm sure there is. I suppose the other option we have is a short spillover hearing to deal with any unresolved matters, and that might include this one.

CHAIR: Well, I don't think we're going to recall program 2.5 tomorrow. We can have a private meeting about it in the morning.

Senator WATT: Can I keep that option open about a spillover hearing?

CHAIR: That's the right of every senator.

Ms Edwards: Senator, we did of course come prepared for the questions, but this is a grant none of us is aware of and our initial inquiries suggest that there is no such grant. Obviously, it's late now. So I would be keen to say that the officers have come prepared.

Senator WATT: Sure.

CHAIR: If we could confirm that there is no such grant, that might then dispense with the matter.

Senator WATT: Once we get the answer to that question you've taken on notice about the grants distributed by this PHN, I'll know whether we need to pursue it any further.

CHAIR: Excellent. All right. I believe that is it for 2.5?

Senator WATT: Yes.

[21:47]

CHAIR: We can excuse the officers from program 2.5, inasmuch as they are not required for later programs. We'll move on to 2.6. I believe, Senator O'Neill, you only have a couple of quick questions?

Senator O'NEILL: I do. I hope that I've got the right dot point, because this is always a bit of a challenge. I asked some questions on notice, with regard to the Hunter, New England and Central Coast PHN, which you might be familiar with.

Ms Edwards: Yes.

Senator O'NEILL: My questions go to that. According to a statement from the Department of Health dated 7 May 2018, which was published in the local paper, the *Peninsula News*, on Monday, 21 May, the department stated:

> The remaining funding—

of the $100,000 supposedly allocated to the resolution of matters concerning the lack of access to general practitioners on the peninsula—

> is available to address additional identified needs of the Hunter, New England and Central Coast community.

But, according to written answers on notice to me, 'The $100,000 in funding remains allocated to support the work of the committee.' Which answer is correct—the statement or the answers to questions on notice?

Ms Cole: Sorry, Senator, when was the statement made?

Senator O'NEILL: The statement was provided to *Peninsula News* and it was published on 21 May.

Ms Cole: Who provided the statement?

Senator O'NEILL: The department.

Ms Edwards: Oh, okay. And that was more recent than the answers to questions on notice?

Senator O'NEILL: And then we received your answers to questions on notice that said, 'The $100,000 in funding remains allocated to support the work of the committee.' One of them is correct and one of them can't be.

Ms Cole: I think actually both of them are correct. One is a subset of the other, if you see what I mean. The PHN is required to provide assistance—to do a needs analysis and then provide services as appropriate.

Senator O'NEILL: That is their standard operating practice, isn't it?

Ms Cole: Yes, to the community.

Senator O'NEILL: Yes.

Ms Cole: And in this particular case they were also allocated a certain amount of money to be available.

Senator O'NEILL: When you say they were allocated a certain amount of money, they didn't have money allocated to them. They had funds within their remit that they chose to use in a particular way. They were not given an additional $100,000, were they?

Ms Cole: No. You are correct. My apologies for the clumsy phrasing.

Senator O'NEILL: I'm less concerned about that and more concerned about getting the truth to the community, because it looks like they've been very misled.

Ms Cole: The $100,000 was set aside by the PHN to deal with the workforce issue, and there was a committee set up in order to facilitate that work on that issue in conjunction with the relevant local GPs and so forth.

Senator O'NEILL: Can the department guarantee that what remains of the $100,000 will be solely used to fix the GP crisis on the peninsula?

Ms Cole: It may be that the remainder of the $100,000 is not actually required, because my understanding of the answer that we gave to you also provided you with quite a bit of information about some improvements, including additional doctors and registers that had—

Senator O'NEILL: We'll get to that. My question is: can you guarantee that the $100,000 will be used to fix the GP crisis on the peninsula?

Ms Cole: As it's a decision by the PHN, no, I cannot guarantee that.

Senator O'NEILL: When did the PHN or the department decide to reallocate the $100,000 to address issues within the wider PHN area?

Ms Cole: I don't believe that decision has been made. As I was trying to explain earlier, one statement is a subset of the others. For me to say that the money allocated by the PHN in the broad is to the benefit of that community and then a certain amount of that money has been allocated to the PHN to address—

Senator O'NEILL: Let's get to that certain amount. The myth that's been created in the community is that there's $100,000 that was allocated specially in addition to what was going on with the PHN. A special $100,000 fund was given to the PHN to fix the problem. That's not the case. They already had the $100,000 and they decided to dedicate it to this task. Of that $100,000, you gave me an answer to a question on notice that indicated $2,000 of the $100,000 has been spent. Is that correct?

Ms Cole: That's correct.

Senator O'NEILL: And how did this $2,000 payment, which constitutes, according to what I understand, meeting fees, contribute to the recruitment of GPs to the peninsula? And who got the $2,000?

Ms Cole: I assume the meeting fees were essentially to cover the costs of some of those people taking out time from their professional day in order to attend the meetings.

Senator O'NEILL: So are you telling me some people who attended a meeting got paid?

Ms Cole: That is possible, but I will double check with the PHN as to exactly what they meant.

Senator O'NEILL: Some people got paid and others didn't get paid, but they attended a number of meetings?

Ms Cole: Please me take that on notice, and I'll come back to you with a breakdown on that $2,000.

Senator O'NEILL: Was the $2,000 used to directly recruit any GP to peninsula or is the $2,000 solely allocated to meeting fees?

Senator McKenzie: The officer has taken your question on notice on the breakdown of the $2,000.

Ms Cole: I have taken it on notice. I'll come back to you.

Senator O'NEILL: Do you dispute that the $2,000 is for meeting fees?

Ms Cole: That is what we were advised.

Senator O'NEILL: That's right.

Ms Cole: It was for meeting costs. Precisely what that comprised I will take on notice for you.

Senator O'NEILL: Why did the PHN decide not to corral the $98,000 that remained to solve the problem for the people of the Central Coast?

Ms Cole: They may yet do that. What the question told you was what the expenditure has been to date, which was the $2,000. It also indicated that, to date, they have already had success in increasing the number of general practitioners in that area.

Senator O'NEILL: You're making a causal link there that is concerning to me.

CHAIR: No, she's not making a causal link, Senator O'Neill. You've inferred that.

Senator O'NEILL: Thank you.

Senator WATT: Perhaps we might see the complete answer the department provided to Senator O'Neill.

Ms Cole: We can get that for you.

Ms Edwards: Chair, I just would note that that series of questions was in 2.5, not 2.6. We're happy to take it, but just so we know where we're up to.

[09:55]

CHAIR: In that case, we have nothing for 2.6, so it got off lightly. We shall move on to 2.7. Senator Urquhart.

Senator URQUHART: My first question is to the minister. Minister, did you travel to Tasmania this week in your capacity as Minister for Rural Health?

Senator McKenzie: In my capacity as Deputy Leader of The Nationals.

Senator URQUHART: So not in your capacity as Minister for Rural Health. Did you travel to Tasmania in your capacity as Minister for Regional Communications?

Senator McKenzie: As I said, I travelled in my capacity as Deputy Leader of The Nationals.

Senator URQUHART: So not representing either of your portfolios?

Senator McKenzie: No.

Senator URQUHART: Okay. That's all I have.

Senator WATT: I have a couple of questions about hospital funding. Is it the government's policy to support the transition to the Commonwealth providing 50 per cent growth funding of the efficient price of health services?

Dr Hartland: The government's policy, as articulated in its offer to the state, is it will provide 45 per cent of efficient growth funding.

Senator WATT: So 45 per cent rather than 50 per cent?

Dr Hartland: That's right.

Senator WATT: Minister, I note that the coalition policy at the 2013 election stated that a coalition government will support the transition to the Commonwealth providing 50 per cent growth funding of the efficient price of hospital services as proposed. That's not your policy now?

Senator McKenzie: Well, our policy is to provide record funding to public hospitals year on year, state by state, and we've achieved that.

Senator WATT: And is it also your policy, as it was in 2013, to support the transition to the Commonwealth providing 50 per cent growth funding?

Senator McKenzie: I'd have to take that on notice. I was a humble backbencher serving on the community affairs committee at the time.

Senator WATT: I can help you out. The answer is no. And we've just heard that in fact government policy is 45 per cent of growth funding. So you're no longer abiding by the commitment made in 2013?

Senator McKenzie: I think we've made our commitment to publicly funding hospitals clear. It's supported by three ALP state governments—the NT, WA and ACT—and three Liberal governments. So it is a $30.2 billion increase, and I think it represents great value for money, as both ALP and Liberal state governments have recognised.

Senator WATT: You do accept that the Commonwealth is providing less funding to public hospitals at a 45 per cent share than it would be if it were providing the 50 per cent share that it committed to in the 2013 election?

Senator McKenzie: I also understand that policies do change over time, under different ministers et cetera. That's a normal part of governing.

Senator WATT: So there has been a policy change?

Senator McKenzie: Well, I think that's evident.

Senator WATT: Right. And policies change—

Senator McKenzie: But I think what we've got to look at, Senator Watt, is the outcome, and the outcome of that policy change has seen record funding delivered across every single state and every year and I'm very, very happy—I've got the table here to actually go through each and every state over the forwards around the percentage increase and how we are investing more than even state governments themselves at a higher rate than they are in their own public hospital systems, which is why the Northern Territory, ACT, Western Australian, New South Wales and Tasmanian governments have actually recognised the benefits of the funding agreement.

Senator WATT: As you know, Victoria and Queensland are yet to sign on to the deal. What are their concerns with the agreement?

Senator McKenzie: I'd be concerned about Queensland not signing on to the deal given that Queensland and WA, and South Australia previously, were three states who'd either flatlined their state contribution or were decreasing their state contribution to their own public hospitals. I hope Queensland take advantage of the opportunity that is presented to them through the partnership agreement.

Senator WATT: You don't think they're entitled to more given the coalition's promise of 50 per cent growth funding in 2013?

Senator McKenzie: Is the Labor Party committed to 50 per cent?

Senator WATT: You're in government and you made the commitment.

Senator McKenzie: Very cute, Senator Watt! Given that the majority of states have seen that this represents a significant investment in their state publicly funded hospitals and they want to work in partnership with the federal government, I think it is self-evident that Queensland and Victoria will sign on because it does represent a great deal for the Commonwealth—the Federation.

Senator WATT: You would be aware that the Queensland government says it is still owed money for services provided in 2016-17. Do you know how much money is in dispute?

Ms Edwards: I think we are talking about discussions we've been having with Queensland about reconciliations for previous years. The public statements I've seen Queensland making were in relation to the 2015-16 reconciliation, which at the time the statements were being made was still being worked through. That has now been completely resolved and I understand that the payments of that will be paid to the funding pool in early June. The 2015-16 reconciliation is continuing. I understand that an initial payment is to be made into the funding pool on 7 June. But the ultimate reconciliation is still being discussed via the Independent Hospital Pricing Authority, the funding body's senior staff, and also the states and territories. That is yet to be finalised.

Senator WATT: Minister, the AMA says that the current formula—where the government will meet 45 per cent of the efficient price—will doom our public hospitals to fail and patients will suffer as a result. Do you agree with the AMA?

Senator McKenzie: Obviously no, I don't. I think the offer on the table is generous. It gives states security. It gives them record funding. The governments of the Northern Territory, Western Australia, the ACT, Tasmania, New South Wales and South Australia recognise it for the opportunity that it is. On 15 May *The Australian* reported that 'Bill Shorten's $2.8 billion public hospital pledge does not commit a future Labor government to alter the underlying funding formula'. So I am wondering what you are actually arguing. Are you arguing that you are committing Bill Shorten's government and shadow minister King to changing the underlying formula?

Senator WATT: Have you given up?

Senator McKenzie: We are clear what our formula is. The deal is on the table.

Senator WATT: I thought you were just conceding a change of government.

Senator McKenzie: No, I wasn't at all.

Senator WATT: The AMA is one of the most respected advocacy bodies in our country and they say our hospitals are being doomed to fail by this governments agreements. That doesn't worry you, Minister?

Senator McKenzie: I am confident that, when we look at the record funding that is on the table, that is going to mean more services provided by more health professionals in more public hospitals in more states in every community across the country.

Senator WATT: I have a question for the department. Has the department provided any advice to the government about federal Labor's commitment to a $2.8 billion better hospitals fund?

Dr Hartland: We provided a factual brief.

Senator WATT: Did the government ask for that advice?

Dr Hartland: Yes, they did.

Senator WATT: The minister's office asked for that advice?

Dr Hartland: That's right. Usually it has been my experience that that is an entirely standard procedure.

Senator WATT: You said 'a factual brief'. Did it simply set out what Labor's policy was?

Dr Hartland: It set out the possible factual sources of statements in Mr Shorten's speech.

Senator WATT: Has the department done any work on Labor's policy?

Dr Hartland: We have certainly not advised on the merits of it. That is not our role.

Senator WATT: You don't monitor opposition policies in the lead-up to an election?

Dr Hartland: I don't think it is my role to say that we are in the lead-up to an election.

Senator McKenzie: Well avoided!

Senator WATT: I think the Prime Minister said today it will happen within 12 months.

Senator McKenzie: He is setting little traps all over the place!

Senator WATT: He is out there!

Dr Hartland: Of course we like to be aware of what all the major parties are saying.

Senator WATT: So you've provided a factual brief—

Dr Hartland: Yes.

Senator WATT: but nothing in the nature of recommendations or opinions?

Dr Hartland: Of course not.

Senator WATT: There's only one topic on 2.7, which I'll try to get through as quickly as I can, but you go first, Senator Urquhart.

Senator URQUHART: Minister, this is in relation to the Mersey Hospital. In 2017 the then mayor Steve Martin, who is now Senator Steve Martin—

Senator McKenzie: Nationals Senator Steve Martin.

Senator URQUHART: There were four quotes that he talked about. One was that Michael Ferguson, who, as you'd be aware, is the state minister, was trying to achieve 10 years of funding with ownership by the federal government. He then went on to say that didn't

occur so that wasn't what the health minister nor the general community wanted. Alderman Martin said there were 'no benefits in putting the hospital into state hands'. He said:

There's no more sweeteners that we're getting from the Federal Government in regards to this …

He concluded by saying:

I would've expected a bit more than just annual funding for the next 10 years.

Do you agree with Senator Martin that your funding deal was not what the general community wanted?

CHAIR: He wasn't Senator Martin then.

Senator McKenzie: I think you're talking about a former alderman—is that a local councillor?

Senator URQUHART: Yes, that's right. Do you agree with those comments?

Senator McKenzie: I'm a federal senator, so I would be backing the government's policy of the day. Former Alderman Martin made his commentary in that capacity.

Senator URQUHART: On 24 January 2017, then Mayor Steve Martin said:

The federal government has been attacked by Devonport mayor Steve Martin—

This is a story in *The Advocate*—

for treating residents of the North-West Coast as "second-rate citizens" in the digital age.

He went on to say:

Launceston and 80 per cent of Hobart have a fibre to the premises system—which offers quicker internet speeds.

Alderman Martin said this would leave the North-West Coast of Tasmania at a significant disadvantage.

He then went on to say:

"It's easy to set up a business in Launceston or Hobart—

Unidentified speaker: Last time I looked we were in Health estimates.

Senator McKenzie: Yes.

Senator URQUHART: sorry?—

because the infrastructure is already there and it's there for the future …

Senator ABETZ: What's the NBN got to do with hospitals and health?

Senator URQUHART: He said:

We should be connected fibre to the premises as the rest of the two thirds of the state is.

Then he said:

Fibre to the node is catered for the present day—

Senator ABETZ: Point of order, Chair: what is the relevance of NBN in Health?

Senator URQUHART: Are you saying that NBN isn't a valuable piece of infrastructure that, with innovations in telehealth, could keep people out of hospitals? I'm talking about hospitals.

Senator McKenzie: Nice! Senator Urquhart, I'll pay that.

CHAIR: That is an extraordinarily long bow.

Senator ABETZ: This is worse than Senator Macdonald with the Traveston dam.

Senator URQUHART: Do you agree with Senator Martin that the government is treating residents of the north-west coast as second-rate citizens?

Senator McKenzie: Senator, the piece that you have read out—and I will have to look at it in detail on notice—shows what a strong advocate for his local community now National Party Senator Martin is. The fact is that he stands up and calls it like it is, and believes that his community—

Senator URQUHART: He believes that the government is treating north-west residents as second-class citizens.

Senator McKenzie: needs further services. I think that is a perfect mix for a National Party senator. And he won't be the first National Party senator that critiques government policy, unfortunately. We have a free will in the Nationals and we're not afraid to express it, so I think he'll make a great addition to our party room.

CHAIR: I think that was an extremely long bow, Senator Urquhart.

Senator ABETZ: This was while he was dallying with the Jacqui Lambie Network, but he's seen the light on a number of issues.

Unidentified speaker: Almost seen the light.

Senator WATT: It sounds like he's dallied with every party except the Liberal Party, Senator Abetz. I have one last set of questions here on eating disorders and the MBS schedule. This is the appropriate place to ask those?

Unidentified speaker: That's tomorrow, I think.

Senator WATT: Would that be more a tomorrow thing?

Ms Edwards: Eating disorders in relation to the MBS will be tomorrow, under MBS.

Senator WATT: Okay, we'll hold that for tomorrow.

Senator ABETZ: In relation to the funding of hospitals in Tasmania, is it correct that each year there has been an increase in the funding over the past five years?

Ms Edwards: Yes. In terms of Commonwealth contribution to hospital funding, yes, there has.

Senator ABETZ: Yes. Are you able to tell us what those increases have been?

Ms Edwards: I can tell you the numbers for each year and we can do the maths together—

Senator ABETZ: Let's not bother doing the maths together, much as it be a bonding exercise, I'm sure!

Senator McKenzie: Bonding over equations!

Senator ABETZ: Just give us the raw figures and we'll try our luck.

Ms Edwards: Starting in 2015-16, the figure was $375 million. In 2016-17 it rose to $387.6 million. In 2017-18, to $418.6 million. In 2018-19 it's budgeted to rise to $419.2 million, then in 2019-20 to $433.9 million. Then, over the proposed period of the next agreement, it continues to rise. Do you want those numbers—

Senator ABETZ: No, that's fine.

Ms Edwards: The final figure in 2024-25 would be $515.2 million.

Senator ABETZ: So an assertion that hospital funding for the state of Tasmania has been cut is not able to be borne out by these figures, is it? There has been an increase each year?

Ms Edwards: There has been an increase each year.

Senator ABETZ: Each year.

Ms Beauchamp: And under the proposed new agreement, I think the increase is in the order of 18 per cent, well above CPI and population growth.

Senator ABETZ: Yes, exactly. That does include the already mentioned Mersey Community Hospital arrangement?

Ms Edwards: No, it doesn't.

Senator McKenzie: No, it's in addition to it.

Senator ABETZ: Yes, so the Mersey hospital funding, where the state government has got an exceptionally generous—I can say that now; at the time when I was arguing for the state of Tasmania, of course, it definitely wasn't enough!—$700 and how many million dollars?

Ms Edwards: It's $730 million-ish from memory. I haven't got that briefing in front of me.

Senator ABETZ: Yes, for a period of—

Ms Edwards: For 10 years.

Senator ABETZ: For 10 years. Are you able to advise on the increase in health funding generally to Tasmania? Apart from the—

Ms Edwards: No, I'd have to take that on notice.

Senator ABETZ: All right. Can I ask about the level of bulk-billing, or is that in another area?

Ms Edwards: That's in another area—tomorrow.

Senator ABETZ: Tomorrow morning, thank you. For 2012-13, which was Labor's last full year in office, are you able to tell us what the Commonwealth funding for Tasmania's public hospitals was? Was that $294.1 million?

Ms Edwards: Yes.

Senator ABETZ: Right. And it is currently, for this financial year?

Ms Edwards: For 2017-18?

Senator ABETZ: Yes.

Ms Edwards: It's $418.6.

Senator ABETZ: So $418.6 million. And the Labor Party are running around Tasmania asserting that funding for Tasmania's public hospitals has somehow been cut from the levels that the Labor Party had. So, when they left office, $294 million and, currently, $418 million.

Senator McKenzie: The figures speak for themselves.

Senator ABETZ: Thank you, Minister, a great summary.

CHAIR: In fact, hospital funding has been up in every state in every year, hasn't it, Minister?

Senator McKenzie: Every state in every year, as far as the eye can see.

CHAIR: I just didn't want the rest of Australia to feel they were missing out to Tasmania—

Senator McKenzie: No, no, it is not just Tasmania that's a winner out of this agreement—it's every state and territory.

CHAIR: On that note we will conclude outcome 2. Thanks to everyone who attended and apologies to those witnesses who weren't called up. I'm sure they're not too upset about that! And we move on to outcome 3.

Australian Sports Commission

[22:15]

Senator FARRELL: Thank you to the minister and all the officials for turning up and sticking round for so long.

Senator McKenzie: Saved the best till last, Senator Farrell!

Senator FARRELL: I think that's true, Minister. I thought I'd start by asking some questions about the National Sport Plan. Do you remember that, Minister?

Senator McKenzie: I do. I'm really excited. I hope you're going to be as excited as I am when we unveil.

Senator FARRELL: It's been a long time coming. You remember Minister Hunt, the former sports minister, said that the plan would be funded by a national lottery. Can you tell us where things are up to with the lottery?

Senator McKenzie: I have received some advice from my department around the lottery. As I've stated publicly, it's my opinion based on that advice that rolling out a UK-style lottery, which I think was what was in former Minister Hunt's head when he suggested that, won't deliver for Australia in the Australian context what it has been able to deliver in terms of funding for sport in the UK. That being said, funding for the Sport Plan and beyond will be revealed over time, but that's where my thinking is thus far around the lottery. I just don't think it's going to deliver what it was first proposed to deliver.

Senator FARRELL: Okay. Can we put the lottery in the rubbish bin then and say that that isn't going to be part of the Sport Plan?

Senator McKenzie: I don't want to rule anything in or out. I'm in the final stages of drafting.

Senator FARRELL: So the lottery is still in the mix?

Senator McKenzie: I think there is a range of funding options in the mix for the Sport Plan.

Senator FARRELL: So let's be clear about it: the lottery is still in the mix?

Senator McKenzie: What I'm being clear about is that I don't think it's going to deliver what the former minister thought it would and—

Senator FARRELL: That would normally suggest—

Senator McKenzie: and, Senator Farrell, I don't think there'll be one model of funding to deliver for sport in this country going forward. I think we need to have a very open mind for

how we are going to deliver for sport over the coming decade, and there's a whole suite of funding initiatives going into my considerations around how we're going to fund sport going forward.

Senator FARRELL: Okay. So a lottery might be one of those items in the suite?

Senator McKenzie: It may be, but not in the form it was first considered in.

Senator FARRELL: Can you tell us what form it might re-appear in or re-emerge as?

Senator McKenzie: Not at this stage, but I did promise you midyear and I think we're in the final stages of drafting.

Senator FARRELL: Let's be clear about this. What we were promised was a solid draft by the end of last year.

Senator McKenzie: I know.

Senator FARRELL: What went wrong with that? Why didn't we get that?

Senator McKenzie: A new minister was appointed who has a deep interest, and it's my professional—

Senator FARRELL: No, hang on—

Senator McKenzie: Senator Farrell, you asked me a question. Can I answer?

Senator FARRELL: Yes, you can answer it, but answer it correctly.

Senator McKenzie: I am going to answer it correctly. We got a new sports minister a couple of days before Christmas, and obviously I considered this along with other portfolios over the summer break and considered what was the drafts Sport Plan at that stage. I want to put my mark on it and I want to make sure we get it right. A lot of people have put in for the consultation to this, and I think it's only right and proper that we deliver a sports plan that is holistic, sustainable and provides a vision going forward. If you're wondering where my head is on all this, I think the budget measures we brought down a couple of weeks ago in my portfolio area give you a sense of where I want to focus.

Senator FARRELL: I'm going to come back to some of those. We were supposed to get it at the end of last year. We had a new minister just about at the end of last year. So, I guess, it's a little bit of a surprise that we couldn't had at least the solid draft available by the end of the year. We've now had two sets of estimates this year. We didn't see it at the last set of estimates. We haven't seen it at this set of estimates.

Senator McKenzie: No, I was clear last estimates about when you would see it; I said midyear.

Senator FARRELL: We're pretty close to midyear—

Senator McKenzie: Well, I guarantee: you won't be asking these questions next estimates.

Senator FARRELL: Okay. So do you have a date that you can tell us?

Senator McKenzie: I don't have a date but, Senator Farrell, I want to get it right, and you would want me to get it right and our stakeholders would want me to get this right.

Senator FARRELL: I don't disagree with that, Minister, but we also want to know what this government is doing about sports. Now, for months and years, you've been talking about

this plan, and we don't appear to be getting any closer to seeing it. I think what the stakeholders—

Senator McKenzie: We are getting closer.

Senator FARRELL: Okay, let's work out how close we're getting—is it days, is it weeks or is it months that we're talking about?

Senator McKenzie: Senator Farrell, I know you're wanting to nail it down. Last Senate estimates—

Senator FARRELL: No, it's not me; it's the stakeholders—

Senator McKenzie: No, Senator Farrell, I'm not—

Senator FARRELL: in this area who, as you said, have gone to the trouble of making these submissions to the government, and they want to know when you're going to decide on a national sports plan. All I'm trying to find out from you is: when is that going to be—is it going to be days, is it going to be weeks—

Senator McKenzie: Okay, Senator Farrell, I will have to refer you—

Senator FARRELL: or is it going to be months?

Senator McKenzie: nothing's changed since last estimates when I said to you midyear. We are not there yet.

Senator FARRELL: So we can say that by 30 June this year—

Senator McKenzie: No.

Senator FARRELL: No?

Senator McKenzie: Senator Farrell: when it's right.

Senator FARRELL: Well, what is midyear?

Senator McKenzie: I don't make any apologies for waiting to get this right, but I can guarantee you, Senator Farrell: you will not be asking this question at the next Senate estimates. However, I'm not going to be held down to a day; I'm going to get it right, and it's going to be midyear.

Senator FARRELL: So we're going to see it on the morning of the next set of estimates; is that when we're going to see it?

Senator McKenzie: Absolutely. I won't give you a rolled gold guarantee; I'll give you a real guarantee.

Senator FARRELL: So we will see it on the day of the next estimates—is that what you're saying?

Senator McKenzie: You will have well and truly perused it by then.

Senator FARRELL: We will have seen it before then?

Senator McKenzie: Yes; well before then.

Senator FARRELL: You might recall that Treasurer Morrison proposed an alternative method of funding the national sports plan, which was an arrangement in respect of online gambling. What's happened to that proposal? There was nothing in the budget about it.

Senator McKenzie: No. As I said to earlier questioning, Senator Farrell, I think any proposals for funding for the sports plan, or sports going forward, is part of my consideration.

Senator FARRELL: So we can expect to see an online gambling tax to—

Senator McKenzie: No, I wouldn't say that.

Senator FARRELL: You wouldn't say that? So we're not going to see an online gambling tax to fund sport?

Senator McKenzie: I would say there are a range of funding scenarios being considered by government.

Senator FARRELL: Is that one of them?

Senator McKenzie: I can't confirm that for you, Senator Farrell.

CHAIR: Senator Farrell, if you ask the minister to rule out every potential option, then we're going to be here for a very long time.

Senator McKenzie: I can rule out, Senator Farrell: we're not going to fund it by games tour.

CHAIR: I'm not saying it's not a fair question.

Senator FARRELL: Look, we've got Minister Hunt announcing that we're going to have a sports lottery. We've got the Treasurer announcing we're going to have an online gambling tax. I'm trying to get some sense as to how you're going to fund this. I'm not going through every single potential option; I'm only going through the options which the government itself has raised. Now, can we say—

Senator McKenzie: A range of funding options are being considered by government with respect to funding sport in this country.

Senator FARRELL: Yes. And one of them is a sports lottery?

Senator McKenzie: I'm not running through them, Senator Farrell. You'll just have to wait until—

Senator FARRELL: There are only two of them. Unless there's something—

Senator McKenzie: How do you know?

Senator FARRELL: Well, I don't know. Tell us. You've told us about the lottery. You've told us about the online gambling. What else have you got in mind?

Senator McKenzie: Senator Farrell, honestly, all will be revealed. But this is a serious consideration. Both our high performance and our endeavours around increasing participation for Australians—getting more Australians moving more often—are things I want to see, so we need to get the settings right. And a lot of what needs to occur in this country isn't about money. There needs to be greater coordination between state and federal governments, and communities and sport. I wouldn't think it's all about the money. Senator Farrell, you've been in this space long enough to know that.

Senator FARRELL: Does that mean one of the options is no sports lottery and no online gambling? So no method to fund the sports plan, is that one of the options?

Senator McKenzie: The government's been really clear in our commitment to support sport in this country and participation in physical activity. We have given $230 million in our budget to initiatives that right across the country will be growing participation in targeted groups—ensuring that older Australians are active for longer and ensuring that kids in schools are participating in sport. We know there are only two states in this country, Victoria and

Tasmania, that have compulsory swimming lessons for primary school students. That is incredible in a nation like this where we had upwards of 260 drownings last year. There's a lot of work to be done in in space, and we're committed to ensuring that it happens.

CHAIR: Senator Farrell, just to be clear, I wasn't trying to suggest it wasn't a legitimate question. I was just conscious that you have two colleagues here who also have questions for this area and we have limited time.

Senator FARRELL: Chair, we were supposed to start this session at—

CHAIR: You'll have to talk about that with your colleagues. Senator, you are wasting more time. You have the call for another five minutes and then we are going to hand over to Senator Leyonhjelm.

Senator FARRELL: I have a few questions about the Sports Commission and the AIS staffing. I think you've provided me with some details on notice since the last estimates. The table in response to my question on notice 171 shows a total of just over 572 staff as of 23 March, is that still the correct number?

Ms Palmer: I'll have to call my colleague Carolyn Brassil to give you the full details and the breakdown of that number.

Ms Brassil: Can I get you to repeat the question, please?

Senator FARRELL: Yes. In my question on notice 171 from the last estimates, we were told that there was a total of 574 staff as of 23 March. My question was: is that still the number?

Ms Brassil: The number provided in March was a transition figure, so it represented the old structure of the Australian Sports Commission and some elements of the transition to the new structure. So, in fact, those numbers were inflated from what is a real representation of the Australian Sports Commission structure.

Senator FARRELL: I see. So the number is now lower?

Ms Brassil: The number is lower. The number, maybe for a point of clarification, that we use for pre reorganisation, which we're in the middle of at the moment, is 512 for our core staffing.

Senator FARRELL: Does that figure represent a 50 or 60 drop or there hasn't been a change?

Ms Brassil: We're still in the middle of our transition arrangements, so the number is not final on our structure going forward. We anticipate that the number will come out at around 445, so there is a reduction, yes.

Senator FARRELL: In your table there are about 310 staff in high performance and participation and about 264 in the corporate operations and site services. Is that roughly correct?

Ms Brassil: Is that question 171?

Senator FARRELL: Yes.

Ms Brassil: Again, the numbers are skewed because they represent a transition state and the two structures are overlapping, so they are higher than what we would anticipate. In our original structure, if I can call it that, the staffing numbers for the core component of the AIS

are 165, Participation is 126, Corporate, which includes our site management function, is 145, and the division of Marketing, Customer Insights and Analytics is 72.

Senator FARRELL: Those numbers seem to be different from the ones that we got in the response.

Ms Brassil: Correct. I don't think the ones in the response are a good indication of the organisation. What they represent is the organisation in transition—the numbers represent the original structure that existed, plus the commencement of transition to the new structure. So there are some duplications within those numbers from the question on notice. The more accurate numbers, from an original staffing level, are the ones I just gave you. They're numbers from January prior to our restructure process.

Senator FARRELL: Could have a think about explaining to me how those numbers are different from the ones that I got in the question on notice.

Senator LEYONHJELM: I'm not sure how many taxpayers are aware that the Australian Institute of Sport owns and operates an athlete's resort in picturesque Lombardy in northern Italy. Could the commission please tell us how much this verdant outpost, with its eight full-time staff, costs to run on an annual basis?

Ms Palmer: I'll have to take that on notice. Just a point of clarification: are you referring to the AIS Europe?

Senator LEYONHJELM: I don't have my notes with me. I'm assuming it probably is.

CHAIR: Is it in Lombardy?

Senator LEYONHJELM: Yes, Lombardy. Is there more than one?

CHAIR: Good question!

Senator McKenzie: The AIS Europe operates out of Varese in Italy. It's a site where our high-performance athletes—

Senator LEYONHJELM: Is that in the province of Lombardy? I think we're talking about the same thing.

Senator McKenzie: I'm not sure.

CHAIR: Let's assume we are.

Senator LEYONHJELM: How much does this cost, with its eight full-time staff? Do you want to take it on notice or can you provide information now?

Mr Dunlop: That costs $2.7 million per annum of our appropriation funding.

Senator LEYONHJELM: Can you tell us why it's necessary to operate an AIS centre in northern Italy?

Ms Palmer: Australia is a long way away from the rest of the world, and our athletes compete on a regular basis internationally. For them to be able to compete at the right level they need to be competing in Europe, for example. Our rowers are just about to head off to and will be based at the AIS Europe for a period of time, before they move to the world championships. So it's a perfect launching pad for those athletes. Our para-athletes use it quite regularly because of their special needs. In terms of cost, it means we do not have to transport heavy and significant amounts of equipment like rowboats. They are stored on site at the AIS

Europe. So it's a perfect opportunity for us to save a significant amount of funds by having a base in Europe.

Senator LEYONHJELM: I understand the men's national volleyball team has used this centre as a training base in the past. Why is it necessary for athletes engaged in a wholly indoor sport to train indoors in Italy instead of indoors in Canberra?

Ms Palmer: It'd be on a base so that they're near to where they are going to compete internationally. I don't actually know the particular instance you're talking about for volleyball, but most athletes, prior to any world championship or international event, would travel to a venue close to where they're going to compete so that they can acclimatise and so that they can be together as a team. Often, our national teams don't train together on a regular basis, so they travel to a site that is central in Europe and then, from that base, can travel on. So it's a very cost-effective way for us to ensure that our athletes can perform at their best. We also have medical staff on site, and, in actual fact, they're called on quite regularly to make sure that our athletes are in peak condition.

Senator LEYONHJELM: The men's Australian volleyball team didn't even manage to qualify for the 2016 Olympic Games in Rio, so do you think the AIS is getting good value from basing athletes at this resort in Italy?

Ms Palmer: We don't base athletes there; they're there for short periods of time. Volleyball is just one of many sports that use a venue, including cycling, as I said, and para athletes. Our world champion, Carol Cook, was there last year on, I think, two occasions. So it's the perfect base for a range of sports, and for us to pay for regular travel backwards and forwards from Australia for these types of events would be prohibitive.

Senator LEYONHJELM: What would be a typical length of stay for an Australian athlete at this facility?

Ms Palmer: I can't give you that detail; I'm happy to take that one on notice.

Senator LEYONHJELM: If we can go further with questions on notice, could you provide us with details of the athletes who took advantage of it over perhaps the last 12 months? I don't want names, but I want the types of sports they were involved in.

Ms Palmer: Absolutely.

Senator LEYONHJELM: Thank you.

Senator DI NATALE: I want to go to the $230 million that was budgeted for sport and physical activity initiatives. What were the criteria for allocating funding for some of the specific initiatives? I think earlier you mentioned physical activity was—

Senator McKenzie: They'll be grant programs that community organisations will be able to apply for. So I'm right in the process now of developing those criteria. As soon as possible, we'll be rolling out those initiatives. We've seen that tsunami of interest in women's sport. If you go down to club land, in AFL, rugby, NRL, soccer and cricket, the facilities just aren't there for our young women. Down in Frankston, we had six new junior teams and five of them were young girls, and they just don't have the facilities.

Senator DI NATALE: So that's some of the capital expenditure you're talking about?

Senator McKenzie: That's that program. Then we've got $11.7 million to extend the local champions funding, which is particularly for rural and regional students but also, say, kids

from WA or North Queensland to get to their state and national championships and give them a bit of financial incentive. It's always an oversubscribed program. So we've chosen to back young people on that pathway a bit more. We've got a significant amount of money for community participation grants, which will specifically go to addressing physical activity levels in targeted cohorts—not getting those who are already loving sport more sport but indeed targeting those inactive cohorts in our communities.

Senator DI NATALE: Trying to get new participants?

Senator McKenzie: Yes, getting new participants active. We've got the older Australians initiative. The ageing participation group is really going to be targeted as part of the ageing package, with all those broader benefits that participating in sport and physical activity bring—not just physical and mental health benefits but the social connectedness. That's important for our older Australians. And we've also got the Sporting Schools program. We've extended that for 18 months, so that we're getting into primary schools but also secondary schools, so that we can connect young people with sport in their communities and connect them to local clubs. That's probably to help parents in particular with the cost of living. A lot of parents find it very difficult to pay those fees, particularly for some sports over others, and by getting it into schools we're ensuring that we're assisting that dinnertime conversation: 'We've got three kids. They all want to do soccer and swimming lessons.' That becomes a very, very expensive conversation for most families.

Senator DI NATALE: Capital expenditure, local champions, participation grants, older Australians—they're some of the categories under which—

Senator McKenzie: Yes. Active beginnings is another one, which I think someone spoke about earlier.

Senator DI NATALE: Could I on notice ask for a breakdown of this investment into elite programs versus grassroots sorts of programs?

Senator McKenzie: There are no elite programs announced in the budget.

Senator DI NATALE: And then I suppose capital investment versus participation?

Senator McKenzie: Yes, sure.

Senator Di Natale: Within each of those categories, you say you're working on criteria at the moment?

Senator McKenzie: Sorry, there is current money for high-performance funding, which Kate Palmer might be able to speak on.

Senator DI NATALE: Which is the existing—

Senator McKenzie: Yes, which is ongoing.

Mr Dunlop: The total amount for high-performance funding is $101 million per annum to the pool, which is a high-performance investment pool.

Senator DI NATALE: How does that compare as a proportion of the other expenditure?

Senator McKenzie: The $230 million package—$30 million is for infrastructure, but the rest is around participation. That's over the forwards. That's $230 million over four. And this is $100 million per annum.

Senator DI NATALE: Roughly $50 million per year if it were spread evenly over the participation.

Senator McKenzie: Sorry, just say that again.

Senator DI NATALE: Roughly $50 million per year, so $200 million over the forwards, if you were to average it out?

Senator McKenzie: Yes, that's right.

Senator DI NATALE: You're looking at developing the criteria for each of these specific areas? You haven't done that yet?

Senator McKenzie: No.

Senator DI NATALE: Have you allocated funding to any organisations yet?

Senator McKenzie: No. We haven't got the criteria, so we wouldn't be doing that yet.

Senator DI NATALE: Can I ask whether the Australian Sports Commission has funded or plans to fund the shooters' association of Australia?

Senator McKenzie: When you say 'shooters' association', do you mean Shooting Australia, which is the sporting shooters, our Olympic athletes, or do you mean Sporting Shooters' Association of Australia, which is—

Senator DI NATALE: Perhaps you can fill in each category.

Senator McKENZIE: Yes. Shooting Australia is the national sporting organisation which deals with all our Commonwealth Games and our Olympic athletes who are in shooting competitions. When you say shooting—

Senator DI NATALE: Sporting shooters. I'm thinking of recreational—

Senator McKenzie: Sporting Shooters' Association of Australia—SSAA—is like an advocacy body for shooters.

Senator DI NATALE: Let's go to Shooting Australia. Has there been additional funding for Shooting Australia?

Senator McKenzie: I'm not able to direct what the ASC—the ASC funds our national sporting organisations according—

Senator DI NATALE: Has there been any change? We're talking here competition, elite shooters.

Senator McKenzie: Yes.

Senator DI NATALE: Has there been any change in that area?

Ms Palmer: Shooting Australia receives just over $3 million a year in funding, which has been reasonably consistent for some time. The government has just provided additional funding towards 2020 to Tokyo, and all of our Olympic sports have received a small amount of additional funding towards Tokyo.

Senator DI NATALE: What about any funding for shooters recreationally—sporting shooters, shooting organisations? Has there been any funding?

Senator McKenzie: No.

Senator DI NATALE: No funding committed?

Senator McKenzie: You're talking about—

Senator DI NATALE: Yes, so I've dealt with that.

Senator McKenzie: So you're asking me now?

Senator DI NATALE: Yes.

Senator McKenzie: No.

Senator DI NATALE: There hasn't been any allocation of funds—

Senator McKenzie: No.

Senator DI NATALE: Is there any intention to fund any of these shooting organisations?

Senator McKenzie: I guess we'll have to see—

Senator DI NATALE: under the participation grants?

Senator McKenzie: No intent. There'll be a set of criteria around increasing participation in physical activity and sport. Those funds will be administered by the ASC at arm's length from government. I'm sure they'll dole it out looking at the merits of the applications.

Senator DI NATALE: So how are these grants going to be allocated? You're saying you develop the criteria in conjunction with the commission?

Senator McKenzie: Yes.

Senator DI NATALE: And then the commission allocate the grants. Do they require approval from you?

Senator McKenzie: They will require approval from me.

Senator DI NATALE: And, at the moment, through any of these participation—is there any funding?

Senator McKenzie: It's all new. It was announced two weeks ago. So it's all brand spankers, starting the next financial year—which we still haven't got to. We're madly working on developing that criteria and rolling them out as soon as possible.

Senator DI NATALE: And you have no intention of providing any additional funding for any of the sporting shooters, sporting-shooting associations?

Senator McKenzie: As I've stated, I think the more Australians we can get involved in sport and activity, irrespective of whether it's lacrosse, park runs, clay-target shooting or Little Athletics, that is a good thing. I'm not going to discriminate against sports.

Senator DI NATALE: Are you of the view there should be funding directed to sporting-shooting associations? I'm just testing your intent, here.

Senator McKenzie: I'm of the opinion that a gold medal from a clay-target female athlete is just as important as a gold medal from our hockey team.

Senator Di Natale: I'm not talking about gold medals. This is about participation.

Senator McKenzie: Yes, it is.

Senator DI NATALE: You talked about the—they're separate.

Senator McKenzie: Let's see whether—

Senator DI NATALE: There's the $3 million that's been steady for a number of years, that's targeted—

Senator McKenzie: To our elite athletes.

Senator DI NATALE: to our elite athletes. You said the focus was on increasing participation.

Senator McKenzie: Yes. I won't be discriminating against any sport.

Senator DI NATALE: Are you seeking to increase participation across the board?

Senator McKenzie: I won't be discriminating against any sport.

Senator DI NATALE: Will you be discriminating for some sports? You have a track record of being a strong advocate—

Senator McKenzie: For AFL, for netball, for sporting shooters, for surf lifesaving.

Senator DI NATALE: And for sporting shooters.

Senator McKenzie: I'm sorry, I'm a sports scientist by trade. I'm very proud of my track record in backing sport.

Senator DI NATALE: You have indicated that you're a strong advocate for sporting shooters.

Senator McKenzie: I am.

Senator DI NATALE: I think you're one of the conveners of the group here in Parliament House.

Senator McKenzie: I'm the chair.

Senator DI NATALE: So you have a strong interest. Is your intention to try and increase participation in the sport of shooting?

Senator McKenzie: My intention is to increase participation in sport. I can't dictate what Australians will choose to do.

Senator DI NATALE: But you make the decision about what gets funded, ultimately. You've just acknowledged that.

Senator McKenzie: I'm assuming the Sports Commission will give me some very good advice based on the applications they receive.

CHAIR: We will need to move on. Final questions.

Senator DI NATALE: I'm probably done. I think I'm good with that. I was just interested to see where that was and what decisions had been made. I'll look forward to watching this space with interest.

Senator FARRELL: I thought since ASADA's here I'd ask them some questions, in a few moments, just to make sure their visit was not wasted, was worth it.

CHAIR: Sure. Looking forward to it.

Senator FARRELL: But I'll get back to the questions I was asking before. The figures you mentioned today—we had the number, in a question on notice, of 574. The number today is 512, and you're moving to a number of 445. That would appear to be 67 fewer positions than today. Can you tell us, in that 67, what roles or positions will be lost?

Ms Brassil: No, not specifically. The organisation's structure has changed significantly. To be able to pull out individual roles or positions from one structure to the other's not possible. There's been quite a significant change within our sport-facing roles, being the AIS and our participation area, to deliver on revised strategic agendas.

Senator FARRELL: I've heard the figure of 40 going from the AIS. Does that sound about correct?

Ms Brassil: That is about right. The figure of 165 from the AIS original structure is moving to a figure of around 122.

Senator FARRELL: That's slightly higher: 43.

Ms Brassil: Correct.

Senator FARRELL: Can you tell, us in those changes, what the roles will be?

Ms Brassil: I might call on my colleague Mr Peter Conde.

Senator FARRELL: Welcome, Mr Conde, and congratulations on your appointment to the position.

Mr Conde: Thank you.

Senator FARRELL: Good luck.

Mr Conde: Thanks very much. It would be difficult to give you all 43, but about 23 people will continue doing pretty much the same work they are doing right now, but their employment arrangements would change in that they would be transferred to the sport that they're currently working for, which is a much cleaner and more appropriate arrangement than the way we're engaging with those sports right now.

Senator FARRELL: Will their terms and conditions go with them?

Mr Conde: Yes. That's dictated by the enterprise agreement.

Senator FARRELL: And, as to the other 20 positions, where will they come from?

Mr Conde: They're from a range of positions. It would be fair to say that the AIS's workforce hasn't adapted over perhaps the last 10 years to match the requirements from sport, so this is a period of significant catch-up. I would also point out that what we're talking about there is a net change and more people will be affected. Some of the skills that we actually need to deliver the requirements for high-performance sport now are different to what they were, say, 10 years ago, if that makes sense.

Senator FARRELL: Yes. You've come in to the role with a very big reputation. Perhaps you could expand on where you see high-performance sport going under your administration?

Mr Conde: From my perspective, we have two very clear roles in delivering against our charge of being the peak strategic agency for high-performance sport. I'd describe one of those as leading and enabling a united high-performance system. That is, working very closely with our colleagues in sports and in state institutes to deliver the daily training environment, the high-performance environment—the culture, coaches, sports science and sports medicine—that the athletes are training in. That's our first key role. Our second key role is to deliver to sports those things on the frontiers of human sporting performance that are not readily done by the others, and those things today are not the same as they were 10 or 15 years ago. This is part of adapting. And they shouldn't be the same in 10 years time either.

Senator FARRELL: After the transition that we've just talked about to this lower number, how many coaches will there be?

Mr Conde: The AIS moved out of employing coaches some years ago, in 2013.

Senator FARRELL: So there are no coaches?

Mr Conde: We fund the sports that typically employ the coaches.

Senator FARRELL: What about sports scientists?

Mr Conde: We will continue to employ sports scientists directly for the needs of the campus.

Senator FARRELL: How many of those will there be?

Mr Conde: I don't have that count, I'm afraid.

Senator FARRELL: No, but you could find out for me.

Mr Conde: Yes, I absolutely could.

Senator FARRELL: Good on you. What about researchers?

Mr Conde: Research is conducted by most of those involved in sports science—those who are employed directly by the AIS and those who are employed in sport and in state institutes. One of the things that I think is critical for us in our role of leading and enabling a united high-performance system is to make sure that we connect those people wherever they are so that we can have well-informed research agendas. We need to prosecute those together with those people and with those who are in universities, and that's a continuation of the philosophy that's been in place for some time.

Senator FARRELL: Are there any other groups of sports specialists I haven't mentioned that you employ?

Mr Conde: Sports science and sports medicine covers a very broad array. In sports medicine we would continue to see the AIS as the leader in complex rehabilitation, in establishing policies for sport around the country, as recently has been done with concussion and so on. It is a recent example of the AIS leading across a broad array of sports—Olympic, Commonwealth Games and professional sports. I think that probably hasn't been picked up when you're talking about sports science—

Senator FARRELL: But you could probably break down and do a little table for the numbers in each of those?

Mr Conde: Very easily.

Senator FARRELL: I have quite a few additional questions, which I'll put on notice. Bearing in mind we have only five minutes left, perhaps we could bring on ASADA.

CHAIR: Yes.

Australian Sports Anti-Doping Authority

[22:56]

Senator FARRELL: Can we get a bit of feedback on your role at the Commonwealth Games, which I was privileged to attend? Could we get some feedback on how your operations went? Unfortunately, I didn't get to see your testing site—perhaps another time. Were any issues caused by the 11th hour completion of the cost recovery contract with GOLDOC?

Mr Sharpe: Thanks for the question. Certainly, there were issues along the way in the last-minute delivery of the contract. But GOLDOC and ASADA were well-advanced on the negotiations and the signing of that document. Delays related to finalising agreements for the

standard for the operations with the Commonwealth Games Federation. We managed that and were able to deliver a high-integrity anti-doping program, which was hugely successful.

Senator FARRELL: We talked last time about the Wood review of Australia's sports integrity arrangements. That review has now been provided to the government and we're awaiting the government's response. There was $10.1 million listed in the budget for improvements in anti-doping and testing activities and for the development of the government's response to the recommendations. How much of that $10.1 million will be going to ASADA?

Mr Sharpe: ASADA has been allocated $3.8 million towards delivering a future operating model. Since 2014, ASADA has conducted a number of reviews into our operating model to make sure we deliver a sustainable anti-doping model for Australia. We have been allocated $3.8 million from 1 July and that will deliver on the intent of ASADA and the new operating model. That will deliver new intelligence capabilities and new investigations capability. Proudly, it will increase substantially our education capacity to work in closer partnership with sports—and to be able to reach down further into the grassroots, where it's strongly lacking.

Senator FARRELL: Are there any additional measures outside of anti-doping and testing activities that ASADA will be required to undertake as part of the development of the government's response to the Wood review?

Mr Sharpe: I can't comment on other components of the Wood review outside of ASADA, but I know that ASADA certainly put on record in the past, at the last estimates committee, that it is supportive of a number of different initiatives that were put forward. It's dependent upon the outcomes from the department as to where we lie but we were are certainly supportive.

Senator FARRELL: Table 1.1 on page 255 of the health portfolio budget statement shows a slight decrease in the overall appropriations, from about $18.3 million to $17.8 million. Is that your understanding?

Mr Sharpe: That's correct.

CHAIR: Senator Farrell, we have ticked over to 11 o'clock, so this will have to be your last question.

Senator FARRELL: Well, if it's my last question, can I ask the minister whether she's made a one-off grant of $2.5 million to netball in recent times?

Senator McKenzie: The Australian Sports Commission administers all the funding to national sporting organisations, including netball and AFL, and any money that goes to our professional sports as well.

Senator FARRELL: And you haven't made any direction—

Senator McKenzie: I think that was your last question, Senator Farrell.

Senator FARRELL: Yes, it was.

CHAIR: Thank you, Senator Farrell. That concludes today's examination of the health portfolio. I thank the minister and officers for their attendance. I thank Hansard, Broadcasting and the secretariat staff. Senators are reminded that written questions on notice should be

provided to the secretariat by 8 June 2018. Officers are reminded that answers to questions taken on notice should be returned to the committee by 16 July 2018.

Committee adjourned at 23:01