COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Estimates

WEDNESDAY, 30 MAY 2018

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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Wednesday, 30 May 2018

Members in attendance: Senators Brockman, Di Natale, Dodson, Griff, Hinch, Keneally, Leyonhjelm, McCarthy, Polley, Rhiannon, Siewert, Singh, Dean Smith, Watt.

HEALTH PORTFOLIO

In Attendance

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

Whole of Portfolio

Ms Glenys Beauchamp PSM, Secretary

Professor Brendan Murphy, Chief Medical Officer

Dr Tony Hobbs, Deputy 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, Australian Digital Health Agency

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 (ASC)

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 C

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 Adviser, 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

Mrs Christina Bolger, Executive Director, Regulatory Policy and Performance, Australian Aged Care Quality Agency

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

Ms Rae Lamb, Australian Aged Care Complaints Commissioner

Mr John Dicer, Aged Care Pricing Commissioner

Committee met at 09:00

Department of Health

CHAIR (Senator Brockman): I declare open this hearing of the Senate Community Affairs Legislation Committee. I welcome back Senator the Hon Bridget McKenzie, representing the Minister for Health, Ms Beauchamp and officers from the Department of Health. We are in continuation from yesterday. We will commence with outcome 4 of the Health portfolio: Individual Health Benefits. Is there anything we need to cover before we keep going?

Ms Beauchamp: I just wanted to put on the record and clarify issues related to the PHN in North Queensland, which we said we would follow up on overnight. I will ask Ms Edwards to speak about what we found.

Ms Edwards: We discussed the issue with the CEO of the North Queensland PHN overnight. He has confirmed that there is no PHN funding into the pharmacy at Yarrabah in any way.

Senator WATT: Thank you.

CHAIR: Are we comfortable with that issue?

Senator WATT: Yes.

[09:01]

CHAIR: Excellent. In that case, we will start with outcome 4, program 4.1—guaranteeing Medicare.

Senator WATT: The first thing I would like to talk about is a measure announced in the budget: visas for general practitioners—targeting areas of doctor shortages. I was wondering if someone can explain this measure to us, please.

Ms Beauchamp: We touched on this yesterday—

Senator WATT: We touched on it briefly in passing, yes.

Ms Beauchamp: About the workforce.

Senator WATT: I think the questions yesterday were more about the incentives program for—

Ms Beauchamp: The workforce package in its entirety was yesterday.

Senator WATT: The reason we are asking about this particular aspect here is that it involves the MBS. We did not—that is why we did not pursue this bit yesterday. Can you just refresh our memories about this particular aspect—the changes being made to visas for general practitioners?

Mr Hallinan: The visas for general practitioners measure comes in a context that I think I will just explain to you. General practice workforce numbers have been growing at triple the rate of population for the last five years and almost triple the rate of population for the last 10 years. There have been a range of policies established to really grow the number of general practitioners in the workforce. We tripled the medical school numbers over the last 20 years and we tripled the size of the General Practice Training program over that same time period from around 400 per annum to over 1,500 per annum. The visa measure is about reducing that rate of growth in general practice and numbers entering the system. Combined with domestic supply-side measures to increase general practice numbers, we have had very open migration policy settings for general practice. The numbers coming into the system have been around 2,000 per annum over the last four years from overseas. What this measure does is specifically target a reduction in the growth of that general practice workforce supply. The savings that are derived from that are just a derivation of the relationship between the supply of practitioners and the services being delivered.

Senator WATT: I take your point that overall GP numbers have been growing quickly, but I presume there are still around the country areas where it is difficult to locate GPs.

Senator McKenzie: I think it is a function of a maldistribution. On any analysis, say, 10 years ago we had 2.6 GPs for every 1,000. Now we have 3.6, but they are all on the east coast. So I think it is about—we have supplemented that maldistribution by incentivising overseas-trained doctors in the main to rural and regional areas. This measure seeks to address that whilst not diminishing service provision.

Senator WATT: To pull back on the number of overseas-trained GPs being located in rural and regional areas?

Senator McKenzie: No, that is the second point. Right now, they are providing a crucial service in rural and regional Australia. However, there is still a lot of overseas-trained doctors practising on the eastern seaboard. So it is about restricting in capital cities.

Senator WATT: The program that you have had to date issuing visas for general practitioners—have they been only made available for areas of shortage?

Mr Hallinan: I think it is worth just talking through how the set of regulations that applies in Medicare operates. At the moment there are three different settings. There is one setting if you are an Australian-trained practitioner who has come through the Australian system. There is another setting if you are a migrating practitioner who has permanent residency status and there is another setting if you are a temporary resident practitioner. It is most difficult to access Medicare if you are an Australian-trained practitioner. Australian-trained practitioners at the moment are pretty much channelled into the formal Australian General Practice Training pathway from a hospital setting. There is an option to jump into the medical deputising sector for a short while if you wish, but principally your pathway is through the Australian General Practice Training pathway. If you are a permanent resident practitioner and you are not a specialist general practitioner then, in order to access Medicare benefits, you need to hop on a 3GA program. Those programs are the Medical Deputising Service Program, the Rural Locum Relief Program or the Special Approved Placements Program. That provides some distribution mechanism for those practitioners. Then, for temporary resident practitioners who are yet to have a specialist qualification in general practice, it is actually the easiest or the simplest set of settings that applies to those practitioners. For the first six months they can work in any practice in the country under a locum arrangement. Beyond that, they need to work in a district of workforce shortage, which is any area in an outer metropolitan location of a major city with lower than average access to general practice services or in an after-hours setting, in order to access Medicare billing, or in any rural district of workforce shortage. What this measure attempts to do, combined with other measures in the Stronger Rural Health Strategy, is clarify and simplify those arrangements so that we do not have three different settings for three different practitioner types and that we have better distribution of the practitioners coming into the system. I think the last data we have indicates that almost three-quarters of practitioners under the targeted general practice visa arrangements that are described here are entering major cities rather than into rural and remote locations. So the principle at play is to both reduce the number of practitioners entering the system, particularly targeting major city locations, and better distribute them into areas of need. A couple of bits of context that might be helpful in terms of—

Senator WATT: That has been helpful, but I might leave it there if that is okay and I will keep going with my questions.

Senator McKenzie: It is very detailed.

Senator WATT: It is very helpful. Am I right that the savings that are expected to be generated from this measure are $441 million over the forward estimates?

Mr Hallinan: I think it is $415.5 million.

Senator McKenzie: Yes.

Senator WATT: Okay. I take it from what you have said that the savings will be achieved then simply by granting 200 fewer visas to overseas-trained doctors?

Mr Hallinan: I think at its highest level, yes. But, in practice, there is a little bit more complexity to it than that. I can go into that if you would like. But it goes into interactions between the 3GA arrangements that we have, changing the Medicare billing arrangements for Australian-trained practitioners and market testing through workforce agencies to ensure that visas are being granted for—

Senator WATT: Is another way of putting that that the practical way that the savings are generated is because you will have 200 fewer GPs billing Medicare for their services?

Mr Hallinan: Yes, that is correct.

Senator McKenzie: In specific areas.

Senator WATT: Yes. By the way, what I have been advised is that the $415.5 million figure is the net saving. I understand the savings from Health are $441 million.

Mr Hallinan: Yes, I think it is $441 million. I will just double-check. It is $441.4 million.

Senator WATT: From the health department?

Mr Hallinan: Yes.

Senator WATT: Why is there a difference between those two figures?

Mr Hallinan: There are also taxation changes in the Department of the Treasury, so there will be revenue implications associated with fewer practising practitioners.

Senator WATT: So those GPs will not—you will have 200 fewer GPs paying tax?

Mr Hallinan: In effect, yes.

Senator WATT: Okay. But, again, just confirming then that the way—let us just stick with the number in Health. The $441 million that will be saved in Health will be derived from 200 fewer GPs billing Medicare for their services?

Senator McKenzie: And that will be reinvested within the Health—

Senator WATT: I understand that.

Mr Hallinan: And per annum incrementally over four years. So it is 200 each year going to 800 by the fourth year and terminating after four years.

Senator WATT: It is 800 by the fourth year?

Mr Hallinan: Yes. So, if you think about this as stock and flows, you are reducing the flow by 200, which means that each year—

Senator WATT: Sorry—200 GPs. I thought you meant $200 million.

Mr Hallinan: No.

Senator WATT: So it will be 200 per annum, being 800 fewer over four years?

Mr Hallinan: Yes, 800 fewer in the stock over the four years.

Senator McKenzie: Overseas-trained doctors.

Senator WATT: Yes. How confident are you then that these savings will be achieved?

Mr Hallinan: It has gone through the usual costing processes with Department of Finance. The relationship between the general practice workforce and billing and therefore costs through Medicare and other areas is very strong. We are confident that those savings

will be achieved—in particular, through reducing the growth in the general practice workforce.

Senator WATT: In your work with the other agencies, was there any resistance from other agencies to banking these savings in the budget?

Mr Hallinan: There was the usual costing process where you need to justify the positions that are put. In that justification process, the numbers went up and down depending on what the questions were and what detail we were asked to provide.

Senator WATT: Did Treasury or Finance raise any concerns about whether these savings are achievable?

Mr Hallinan: No, they have been banked and agreed through the usual processes.

Senator WATT: I am sure you are aware that the AMA has argued that these savings will not be achieved because patients will simply move to other doctors, who will still bill Medicare for their services. How do you respond to that?

Mr Hallinan: What we have done is taken a statistical relationship between general practice workforce supply and billing. We have applied that. That is a long-term relationship. Where there is an increase in supply, there is an increase in billing. So we do not see at the moment—if you add a few doctors to the system there will be an increase in services in that region, because patients will be able to go in and see doctors for more things than they have been able to see them for before.

Senator WATT: But isn't that the point? If I am a patient who otherwise would have gone and seen an overseas-trained doctor who has been granted a visa to work here and that doctor does not come to Australia anymore, I still wake up sick that day and I am still going to go and see another GP, who is still going to bill Medicare. So I do not understand how these savings will actually be realised.

Ms Shakespeare: I think it is probably important to look at this particular measure in the context of what is happening with the MBS overall. If you look at the budget papers, the MBS program itself is growing very strongly. There will be a $4.8 billion increase in expenditure onto the MBS so, while there are some measures that may be reducing that growth or slowing that growth, overall it is expected that we will see more services provided to people over the forward estimates.

Senator WATT: So it actually does not generate a saving to the budget in an overall sense?

Ms Shakespeare: It is reduction in growth that we are seeing in the MBS.

Prof. Murphy: Maybe I could come in here. I think when you have an adequate supply of general practitioners, as we clearly do in the metropolitan area, there is no question that, if you go to a very high supply ratio, there is some evidence of perhaps subconscious supplier-induced demand. One could review someone more frequently if you have gaps in your schedule. But I think sick people will always go and get services when they need them. There is at the margins, when you have very adequate supply, some discretionary use of services—maybe coming back to get a blood test result rather than ringing up. So there is evidence, as Mr Hallinan said, that statistically, when you increase the number and supply of doctors, you generate some more services. I think that the data we have is pretty clear. We are not talking

about taking doctors away from service—from areas that do not already have a very good ratio by international standards of GPs to community. We have some of the highest ratios, particularly in our metropolitan areas. If we can reduce what would seem statistically to be an oversupply, there is pretty good evidence that that will reduce some utilisation of Medicare.

Senator McKenzie: We have been very conservative—

CHAIR: Minister, this measure has been supported broadly by stakeholders—

Senator McKenzie: All stakeholders.

CHAIR: including the AMA?

Prof. Murphy: The AMA supports it very strongly, Senator. The AMA did initially question the savings, because the AMA probably do not like the concept of supplier-induced demand. But, in fact, the AMA have softened their response recently. The AMA really strongly supports this visa control measure, mainly because, as Mr Hallinan said, we are targeting it exclusively to metropolitan areas of oversupply. We are not taking any doctors away from access to rural areas where there is genuine undersupply. This measure is designed to address some of the anomalies in the system that can lead to overseas-trained doctors coming into areas that already have adequate GP supply.

Senator McKenzie: I think one of the additional measures in the suite of initiatives is that, over time, domestically-trained doctors will be throughout the system, rather than overseas-trained doctors filling gaps in supply, and therefore quality improving—

Senator WATT: Seeing that you are confident that these savings will be achieved, can you outline exactly which Medicare services will be cut?

Mr Hallinan: I would have to take that on notice.

Ms Beauchamp: I think we have said that Medicare services will not be cut. In fact we are talking about—

Senator WATT: Well, the overall number of services. How do you generate these savings if you are not cutting anything?

Senator McKenzie: There are no cuts to Medicare, Senator.

Prof. Murphy: It is a reduction in growth—

Senator WATT: I am not saying you are cutting a type of Medicare payment out, but you have admitted that you are cutting the amount of money that is going to Medicare because your billing—

Prof. Murphy: We are reducing the growth in Medicare expenditure in the forward estimates. This is not a cut. We are talking about a very substantial growth year on year of about five per cent or more in Medicare services. This is a small reduction in the growth. It is not a cut to any Medicare services.

Senator SINGH: How do you justify the savings, then, if it is not a cut?

Prof. Murphy: It is savings against the forward estimates.

Mr Hallinan: It is a reduction in the growth of Medicare billing. There are a couple of really interesting points. According to OECD data, we now have the third highest general practice to population ratios in the world behind France and Canada. As to the rate of access to service provision, if we take a per-patient access to general practice services calculation, in

2005 we were at about 5.1 services per capita across the country. Now we are at about six services per capita across the country. In cities that was a little bit over five in 2005. In cities, it is now just a little bit over six. In rural locations—Modified Monash Model 2 to 5—we were just over four services per capita at the time. We are now just under six services per capita at the moment in terms of general practice access. The reason for that growth, particularly in rural locations and in cities, is that we have had large supply-side policy increases. We have had a rolling increase in the number of practitioners billing Medicare. That relationship has shown that an increase in the number of doctors billing Medicare through areas that have had a shortage in the past has led to an increase in services and an increase in billing. What we are doing now is slowing that rate of growth because we are now at the third highest, according to OECD data, general practice to population ratio.

Senator SINGH: I have done a bit of maths—$441 million is equivalent to 12 million standard GP consultations. Is that what you are cutting or are you cutting something else?

Ms Beauchamp: There are a couple of things to raise here. The planning target for overseas doctors will now be 2,100. As Mr Hallinan said, there is still going to be an increase in the number of doctors. In terms of reducing the growth, the budget papers clearly state that the $400-odd million is going to be reinvested back into the Health portfolio—they clearly state that. So that would be contributing to the overall increase in the forward estimates of the Health portfolio of over $12.4 billion.

Senator WATT: The thing is: you cannot have it both ways. Mr Hallinan said earlier that these savings will be derived from 200 fewer GPs billing Medicare for services. We have worked out that that works out to about 12 million fewer GP consultations being billed to Medicare. If you are going to get the savings, it actually means fewer services being provided to Australians. If you are saying, 'No, that is not right—we are not cutting anything', you cannot be deriving a saving. It is one or the other.

Ms Beauchamp: I think Ms Shakespeare spoke about five per cent growth in MBS. The number of services is actually increasing substantially. I have not worked out how many million that is on a per annum basis. But you are talking about over five per cent growth in the number of MBS services—I think that is the bottom line.

Senator WATT: So this saving is really illusory, because it is being made up somewhere else?

Prof. Murphy: No, it is not illusory. It is a saving against the projected growth. It is a slight reduction in the projected growth over the forward estimates from what would normally be expected with this uncontrolled migration. There is still a massive increase in Medicare services over the period, but there are just slightly fewer than you would otherwise have expected if you had uncontrolled migration.

Senator WATT: I know that everyone in the Health sphere is terrified of the words 'cut' and 'Medicare' being linked together, but isn't it the reality that, if not for this measure, Medicare funding would have been growing that much and with this measure it will be growing this much? That is a cut.

Ms Shakespeare: There are a range of measures in the budget that are helping us to keep Medicare sustainable. They are not characterised accurately as cuts. They are reductions in growth and expenditure otherwise expected over the forward estimates. In the case of the

overseas-trained doctors, these are not services currently in the system. These are doctors that may have otherwise migrated to Australia over the forward estimates. So it is not accurate to describe these as cuts in services.

Senator WATT: So you do not concede that there will be any Australians who would have gone to an overseas-trained GP and had their services billed to Medicare who will not receive those services from another doctor?

Ms Shakespeare: We are expecting strong growth in the number of Medicare services and Medicare expenditure, as I have outlined. It is $4.8 billion over the forward estimates.

Mr Hallinan: I think it is also worth touching on that as part of the Stronger Rural Health Strategy there is $180 million worth of expansion in practice nurse and allied health services, which will expand capacity in general practice settings to deliver services outside of medicine. That is a growth in the number of services delivered by non-medical practitioners. In that mix there will certainly be greater access to service provision and it will support changing models of care in general practice settings. That is a complementary measure to support that access to services through the system. Many of those services will not be billed to Medicare, because they will be provided through the Workforce Incentive Program and only some of the services provided by nurses in allied health in those arrangements are Medicare billable. I think that is just a complementary measure that is worth noting here. We do think there will be greater capacity in the system to see patients as a result of that.

Senator WATT: Which MBS items will be affected through this savings measure? Presumably it is mostly going to come from general practice.

Mr Hallinan: Principally from general practice, but we would also see some reduction in referrals and other activities.

Senator WATT: Referrals to specialists?

Mr Hallinan: And pathology and diagnostic imaging.

Ms Beauchamp: Can I also add too that the whole point of the workforce strategy was to better target general practitioners to areas of doctor shortages. So there will be more people who will be able to access a GP. I think talking about MBS items is probably irrelevant.

Senator McKenzie: It is about actually ensuring that Australians, no matter where you live, have access to a GP. Right now you are talking about areas of oversupply when there are a series of areas across this nation with undersupply, which this package in its entirety seeks to address so that those in rural and regional areas can get the services.

CHAIR: I think that is the point, isn't it, Minister?

Senator McKenzie: Yes, that is the point.

CHAIR: You have to look at the whole picture. Can you just talk us through what the government has actually done to guarantee the future of Medicare?

Senator McKenzie: We have provided the guarantee. We have growth going on. In terms of the Rural Health Workforce Strategy we are going to be supplying more than 3,000 doctors—that is a conservative estimate over the next 10 years—3,000 nurses and allied health professionals. We have incentivised GPs to have multidisciplinary teams around their practice. As Mr Hallinan said, the services that will be provided to those communities through that GP practice with their multidisciplinary allied health team will not all be billing the MBS.

They will be providing those services through the practice and as it works. So I think there is a range of strategies that we have carefully calibrated, I might say, and putting one measure out aside from the others does not actually give you the whole picture of how service delivery across the nation will increase, which is the point Ms Shakespeare is making.

Senator WATT: Just coming back to this point about the MBS items that will be affected, you have said GP services and referral to specialists—so specialist treatment?

Prof. Murphy: If specialist treatment is warranted, those referrals will happen.

Senator WATT: So there will be not be a saving?

Prof. Murphy: Unless that specialist service is perhaps not particularly, should we say, necessary. It might be just an extra opinion. If someone has a real need, we have an adequate supply of general practitioners—an over-adequate supply. So people who really need medical services will certainly be getting them. We are not talking about reduction in specialist services in the main. There may be some pathology and imaging that is ordered perhaps that is not—we know there is a fair bit of waste already in the system. Some tests and things are ordered that perhaps—

Senator WATT: How do you know that that is as a result of overseas-trained doctors?

Prof. Murphy: We know that—the statistics show that, where you have an excess supply over what is deemed statistically, more services seem to be generated. There is no evidence that those services add significant value to the health outcomes. So, as long as you have an adequate supply and good access for people who are unwell, I do not think there is an issue at all.

Mr Hallinan: I think it is worth noting that this comes in response to calls from the sector over years now to take medicine from the skills list for migration purposes. The purpose of taking medicine from the skills list for migration purposes is to reduce the growth in doctor numbers. That comes from the sector and the sector is calling for it. That is why this has been broadly accepted by most stakeholders in the system.

Senator WATT: Minister, just in response to what you were just telling us about Medicare, it has been brought to my attention that this budget put Medicare growth at nine per cent in real terms between 2018-19 and 2021-22, whereas the previous budget forecast 10.9 per cent growth between 2017-18 and 2020-21. Does that mean that people are expected to use Medicare less in coming years than what you thought this time last year?

Ms Shakespeare: I think the better characterisation of that is that there will be some moderation in the growth of Medicare. That is coming from a number of activities and government decisions implemented as a result of the MBS task force. We are trying to I suppose bend the curve of Medicare expenditure to keep it sustainable by targeting lower-value and obsolete services on the MBS. That is helping us to keep growth at sustainable levels.

Senator WATT: So you are trying to bend the curve to reduce spending?

Ms Shakespeare: Where that spending is at the moment going towards low-value and obsolete care that is not reflecting best clinical practice.

Senator WATT: Just getting back to the GP measure, which geographic areas do you expect to be affected as a result of this change to overseas-trained doctors?

Mr Hallinan: Major cities.

Senator WATT: And how are you actually going to implement that? How are you going to ensure that it is major cities only and not rural and remote locations?

Mr Hallinan: In order to grant the visa, we will be working with the Department of Home Affairs. We will be using another complementary measure in the Stronger Rural Health Strategy—I think we call it the heads-up tool—to do an assessment of local need across the country and identify areas that have, based on population demand and supply statistics, much greater access than other parts of the country and limit visas into those areas. That will happen through a process combined between the department, rural workforce agencies and the Department of Home Affairs to reduce the number of visas granted to a planning target of around 200 fewer than previous years.

Senator WATT: Would you on notice be able to provide a breakdown of the expected savings by year, Medicare item or group of items and geographic area?

Mr Hallinan: We can take that on notice and see what we can provide.

Senator WATT: Just to clarify, then, I think you said this bending of the curve or the moderation in growth that you are expecting in health spending is going to result from this measure and the various other saves that are contained in the budget.

Ms Shakespeare: There are a range of measures impacting on growth. There are other measures in the budget that are increasing growth. It is a mix of, I suppose, additional expenditure and then areas where we are able to moderate growth.

Senator WATT: Thank you.

Senator GRIFF: I have a handful of questions. Just in relation to the MBS Review Taskforce, how much does it actually cost to operate that task force, including department costs so far?

Mr Weiss: The expenditure on the MBS Review Taskforce to date—the administered expenses—is $19.9 million as at the end of 30 April this year.

Senator GRIFF: How many item numbers have been abolished or changed?

Ms Shakespeare: I think that is probably something we would need to take on notice. There are quite a few different views that have impacted on areas of the MBS where items have been restructured. Some have been abolished and some have been changed. It is quite a complex question. We will see what we can provide on notice.

Senator GRIFF: That would be great. Have there been recommendations for change that have been made to the minister that are awaiting the minister's approval?

Ms Shakespeare: Yes, there are currently, I understand, 11 recommendations that are being considered by government for a response out of a total of just over 100 that have been made to the government.

Senator GRIFF: My understanding is that 38 recommendations were accepted. How many were not accepted by government?

Ms Shakespeare: I think the 38 that you are referring to were part of an announcement on 29 April this year. So 40 recommendations were responded to, 38 were fully accepted as recommended by the task force and two were accepted in part relating to spinal surgery.

Senator GRIFF: So nothing was rejected?

Ms Shakespeare: No.

Senator GRIFF: I just want to refer to the recent changes to the knee diagnostic imaging, which is also in that same release—limiting the ordering of MRIs by GPs to those under the age of 50. What is the expected cost saving from that measure?

Ms Shakespeare: I think generally we have to just preface it with all of those comments that we have previously been making. This is not actually a saving in terms of actual reduction in MBS expenditure. It is reducing the overall strong growth in the MBS. But the impact of those recommendations on MBS expenditure is $89.5 million over four years.

Senator GRIFF: Won't patients over 50 just end up having the MRI ordered by a specialist so there is actually not any direct saving?

Ms Shakespeare: Perhaps we can just take you through what the task force recommended and why it recommended that. I think the task force identified that since GPs have been able to order MRIs—I think that was from about 2013—there has been a large increase in the number of MRIs for people aged over 50. There were concerns that this was resulting in unnecessary treatment for many of those people because for over-50s, generally, knee pain would be caused by chronic conditions or osteoarthritis, which does not require MRI to diagnose. So that was potentially having an impact on MRI resources that were available for people who needed MRIs. But also people were being sent for tests that they did not need and delays in their treatment for conditions like osteoarthritis, which does not require diagnosis by MRI. Given the very large number—I think something like 45 per cent of MRIs were for people over 50—that we were seeing I think in 2014, they recommended these restrictions. So it was really about encouraging best-practice care for people who have knee conditions over that age and also making sure that we have the best use of MRI resources in the health system.

Senator GRIFF: And it is quite a substantial savings—you said $89.5 million. I would just like to—

CHAIR: Can I just jump in there on a similar question? In this committee's inquiry into MRI, there was evidence from both medical professionals and diagnostic imaging professionals that lower back MRI should also be considered in the same vein. Is that currently under consideration?

Ms Shakespeare: I am not sure, Senator. We would need to take that on notice.

CHAIR: Okay.

Senator GRIFF: The new arrangements for after-hours GP services—they kicked in from 1 March this year?

Mr Weiss: That is correct.

Senator GRIFF: Are you able to say what, if any, savings there have been to date?

Ms Shakespeare: We can talk about the model reduction in growth that was anticipated to arise from that measure. We can also talk about what we have seen since the changes were put in place on 1 March.

Senator GRIFF: What are you projecting the total saving to actually be in the first instance?

Mr Weiss: The projected reduction in growth from that was $276.4 million over four years. It was included in the measure added to the 2017-18 MYEFO.

Senator GRIFF: The only information I can access at the moment—looking at the Medicare item 585, the only stats that I can see here relate to March, so that could just be the full month. But I imagine you would have exposure to perhaps a little more than that. What is interesting, having a look at this, is that, if you compare February to March, when everything kicked in, is that a lot of states have had a reduction of around 70 per cent. I imagine that is continuing. Are they the numbers that you are seeing as well?

Ms Shakespeare: We are seeing a reduction in the use of urgent after-hours items. It is probably better to compare—there is seasonal variation month on month, so, rather than comparing between February and March, we should look at the figures from last year in the same month. But that is also confirming a reduction in the overall number of services. That is what we did expect to see. We had already been seeing a reduction in the number of urgent after-hours services before the new items were introduced. That was, I think, as a result of compliance activities that we have had underway and also, I suppose, general heightened scrutiny of what was happening in the industry.

CHAIR: And, again, the AMA and the royal college supported those changes. Is that correct?

Ms Shakespeare: They did.

Senator GRIFF: I think even if you compare back—again, comparing March 2017 and March 2018, yes, absolutely, they are quite substantial savings. So it definitely has been a worthwhile exercise. But there is one thing that I am somewhat intrigued with even just looking at these March figures: all states, pretty much with the exception of South Australia, have had a very significant reduction. South Australia, interestingly, has only dropped about 30 per cent, yet for the majority of others it has been something between 60 per cent and 70 per cent.

Ms Beauchamp: I guess that reduction would have been on a very high base. So, whilst the growth in GP services increased 27 per cent from 2010-11 onwards, I think the growth in after-hours services was 170 per cent. When you are looking at those reductions, I think there has been a slowing of that growth on what is an incredibly high growth.

Senator GRIFF: As you will recall, over the last couple of years, I have been mentioning this one pretty much every estimates, and it is very pleasing to see the impact that it has had. Do you have a view as to why South Australia has not achieved the same level of reduction?

Ms Shakespeare: We can certainly look at that. The data is still quite young. The other thing we would need to look into is whether or not we have the full picture given it has only been in place for a couple of months. But certainly we are expecting to see a reduction in the number of urgent after-hours services. According to the findings of the MBS task force, there were services that were being billed as urgent when they were not genuinely urgent. I think that is what we are seeing reflected in the numbers. We are happy to have a look, though, at state-by-state variations.

Senator McKenzie: Was this a case where the MBS item number is for urgent consultations but you were actually able to make an appointment?

Ms Shakespeare: That was a fairly widespread practice identified by the MBS task force.

CHAIR: Is it possible that South Australia just had a lower starting base?

Senator GRIFF: No, South Australia had one of the highest starting bases. It is also the national office for the after-hours Medical Deputising Service, which is an interesting factor that might perhaps be a factor in this exercise. Have there been any evaluations of emergency department presentations since the changes to see if there has been any impact on emergency services?

Ms Shakespeare: There has been no evaluation done since these changes were put into place on 1 March. But I think it is important to note that the task force looked at the impact of the growth of the urgent after-hours services and found no correlation between a reduction in emergency department presentations. So we would not be expecting to see necessarily an increase in emergency department presentations a result of these changes.

CHAIR: I have a couple of questions on the MBS review. Is this a defined project in time or is this now going to be an ongoing, constant—there is going to be a constant review process?

Ms Shakespeare: The government has funded the MBS task force presently—I think there is $44.2 million in funding—until the end of 2019-20. That is including implementation of recommendations that might come from the task force. One of the matters that the task force has been asked to look at is what arrangements should be put in place after the task force to make sure that the MBS remains contemporary and reflects best clinical practice over time.

CHAIR: Yes, because I would have thought this was not something that was all going to be solved with one look at it. It is going to be something that needs constant—items will become less relevant to the modern medical environment and will need to drop off or change and new items will constantly be coming on.

Mr Weiss: An explicit part of the terms of reference of the task force is to provide advice to the government about an option or options for an ongoing mechanism for review of the MBS.

CHAIR: Minister, the MBS task force has bipartisan support—that is my understanding. Is that correct?

Senator McKenzie: Yes.

Senator WATT: Just turning to the MBS review, I think I am right to say that the last two budget updates have included $598.7 million in net savings from that review. Is that correct?

Ms Shakespeare: That sounds correct.

Senator WATT: The way I have got to that is that there were net savings of $409 million in the 2017 MYEFO and $189.7 million in the 2018 budget. So, adding that together, it is basically $600 million. Could you on notice please provide a breakdown of all spends and saves from the MBS review so far by item or group of items and year across the forward estimates?

Ms Shakespeare: I think by item would be incredibly difficult. As I said, the MBS task force recommendations often result in restructuring of items. But I am happy to take on notice what information we can provide.

Senator WATT: Is there a way of doing it by group of items?

Ms Beauchamp: We may be able to do it by group.

Senator WATT: Thank you. So that is the savings across the forward estimates—about $600 million across the forward estimates. On the flip side, it looks like there has been $36 million of new or amended MBS items listed over the same period. Does that sound right? Where I have got that from is that in MYEFO there were new or amended items of $10.6 million and in the budget just recently there were $25.4 million.

Ms Shakespeare: Those items are generally going to be things that result from recommendations from the Medical Services Advisory Committee, which is a separate process from the MBS Review Taskforce.

Senator WATT: Right, but, however it comes about, the end result is new or amended MBS items involving an additional cost to the budget?

Ms Shakespeare: There are certainly new and amended MBS items that come out of the Medical Services Advisory Committee that have an additional cost to the budget. There may also be recommendations that result in a reduction to the MBS budget out of MSAC. There will be recommendations from the MBS task force impacting on the forward growth of the MBS, some of which add to that growth and some which moderate that growth.

Senator WATT: This is not a trick question. I am actually trying to give you credit for some extra spending on Medicare. It looks like a total of $36 million.

Ms Shakespeare: I would need to take that on notice.

Senator WATT: So, putting that together, we have net savings from the MBS review of $598.7 million and new amended listings of $36 million, so there are net savings from the MBS review and under MBS items of $563 million?

Ms Shakespeare: Your mathematics would appear to be correct.

Senator WATT: My question is what—

Ms Shakespeare: Those are two separate processes though. If you are going to run, I suppose, a tally of what is changing MBS expenditure, there are other items that need to be taken into account too—for instance, indexation that is now being applied to the MBS from a budget measure last year.

Senator WATT: My question really is: what is happening to that saving of $563 million that has been generated from the MBS review or Medicare items?

Ms Shakespeare: That is moderating the growth of $4.8 billion in the MBS that we are seeing over the forward estimates.

Senator WATT: So it is being used to reduce the overall expenditure on health?

Ms Shakespeare: It is part of the modelled expenditure that we are expecting to see on the MBS over the forward estimates, which includes increases in expenditure, reductions in expenditure in some areas, increases through indexation of some items, expectations around population growth—it has all been modelled into the MBS forecasts, which are strongly growing and demonstrating through the budget papers a growth of $4.8 billion over the forward estimates.

Senator WATT: But it is the case, isn't it, that the $563 million in savings being generated from the MBS review—that money you say is being used elsewhere in the system—is certainly not being used to provide new items or improve access to MBS items?

Ms Shakespeare: It is assisting new items. The new items that get put onto the MBS are as a result of submissions made and recommendations from the Medical Services Advisory Committee.

Senator WATT: But there are only 36—

Ms Shakespeare: We do not ask the MSAC, 'Can you please generate X dollars worth of—

Senator WATT: But there is only $36 million worth of new or amended items whereas there is a cut or savings or moderation or curve bend of $600 million?

Senator McKenzie: What you may have missed, because you were talking to a colleague when Senator Griff was having his questions answered, was some of the issues with accessing certain Medicare benefit schedule numbers, particularly around after-hours care and the schedule numbers we have on urgent after-hours care where we were actually seeing providers booking that in and charging the system for what essentially was not clearly urgent care. That was a whole series of questions.

Senator WATT: Is that connected to the MBS review?

Senator McKenzie: Yes. There are some really serious things that have been recovered through the review that you might have missed.

Senator WATT: Yes, we are on common ground that there have been about $600 million in savings generated from the MBS review. I think we are on common ground that there is about $36 million in new spending as a result of new listings or amended listings. So that gives us a difference of about $563 million that is being taken out of the system as a result of the MBS review and may well be being used elsewhere.

Senator McKenzie: It is invested in—

Senator WATT: Yes, but there is a reduction in MBS spending as a result of the review.

Ms Beauchamp: Can I just clarify that we have taken on notice the new items of expenditure, so that mathematics may be right or wrong. I think the bottom line is that the MBS review was not about a money exercise. I think reviewing 7,500 items was about ensuring that we had a contemporary MBS system that absolutely delivered quality of care for patients. I think Ms Shakespeare has already spoken about the growth and changes in growth of MBS and that we are looking at a nine per cent real growth over the forward estimates, with a $4.8 billion increase over that period. So any changes in spending, whether they are expenses or reductions in growth, are being reinvested back into the Medicare MBS bottom line.

Senator McKenzie: That is right.

Senator WATT: Okay. So you are reinvesting those savings in growth and in the health budget that would have happened anyway?

Ms Beauchamp: Into the MBS.

Senator WATT: It would have happened anyway as a result of population growth and service increases. This is being used as a funding source?

Ms Shakespeare: There are also other budget measures that you have not mentioned that need to be taken into account. Indexation, which was recommenced from 1 July last year, also has a significant impact on expenditure under the MBS. So the fact that we now have another year in the forward estimates—in 2021-22 indexation, there is half a billion dollars in that year through the application of indexation.

Senator DEAN SMITH: I just want to stay with the issue of the MBS and the decision to reinvest back into Medicare, because that is the conscious budget decision—is that correct? The government could have done other things with those savings—is that correct?

Ms Shakespeare: Yes. So certainly there is a commitment that any savings generated will be reinvested in Medicare.

Senator DEAN SMITH: So it is a policy commitment?

Ms Shakespeare: Yes, that is correct.

Senator DEAN SMITH: So the government could have decided not to reinvest the money into Medicare?

Ms Shakespeare: Yes.

Senator DEAN SMITH: Have previous governments decided to take savings from Medicare and not reinvest them in Medicare?

Ms Shakespeare: I am sure there would have been many decisions on particular budget measures over the years. I am not aware of any in particular, though.

Senator DEAN SMITH: Secretary, are you aware of any previous budget measures that may have been undertaken by governments which delivered savings from the MBS but were not reinvested into Medicare?

Ms Beauchamp: I am not too sure of the history, but it is probably the first time that we have agreed with Treasury and Finance that any reductions in growth are actually being reinvested back into the program. So in the sense of some of the policy decisions that have been taken around MBS and PBS I think that is a real win for us as a portfolio.

Senator DEAN SMITH: So the policy decision to reinvest has some historical significance because that is not how things have necessarily been in the past?

Senator McKenzie: Agreed.

Senator WATT: Such as in 2014?

Senator McKenzie: We can go back further, Senator Watt, if you would like to.

Senator DEAN SMITH: We will go even further—

Senator McKenzie: Maybe we will later in aged care.

Senator DEAN SMITH: to the budget measures of 2009-10—I have the document in front of me here—Medicare Benefits Schedule Capping Extended Medicare Safety. I am quoting now: 'This measure will provide savings of $257.9 million over four years'. Again, in the budget measures of 2009-10, Medicare Benefits Schedule Capping Extended Medicare Safety Net Benefits: 'The measure will provide net savings of $193.7 million over four years'. Again, the budget initiatives of 2009-10, the Medicare Benefits Schedule Removing Double

Billing: 'This measure will result in savings of $119.6 million over four years'. Again, budget measures from 2009-10 in regard to the Medical Benefits Schedule promoting better use of selective spinal X ray items: 'This measure will take effect from 1 January 2010 and will result in savings of $17.1 million'.

Senator McKenzie: Senator, I do not have that document. But are you essentially saying that the former Labor government cut Medicare whilst our government is guaranteeing it?

Senator DEAN SMITH: I am saying that the previous government set a precedent where it saved $588.3 million cumulatively in one set of budget measures in 2009-10 and did not reinvest it into Medicare. It took the savings and did not reinvest it into Medicare. What I have heard this morning is that this government has taken a conscious policy decision for the first time to reinvest efficiencies from the MBS back into Medicare. We only need to go back to 2009-10 to see that the previous Labor government took savings of $588.3 million and did not reinvest them into Medicare.

Ms Beauchamp: Just to confirm, I am quoting from the Treasurer's Budget Paper No. 2 that net savings over five years from 2017-18 have already been reinvested by the government in Medicare.

Senator DEAN SMITH: What is the page, Secretary?

Ms Beauchamp: It is page 110 of budget paper No. 2.

Senator DEAN SMITH: I do trust you, but, as President Reagan used to say to the Russians, 'Trust and verify'.

Ms Beauchamp: It is just after the dot points.

Senator McKenzie: It is above the table—'Guaranteeing Medicare'.

Senator DEAN SMITH: That is correct. Thank you very much.

Senator WATT: I just have some questions about MRI licences and particularly the MBS payments that arise from them. You might remember we had a Senate inquiry last year about the allocation of MRI licences. The department told that inquiry that the government had granted just four Medicare MRI licences since it was elected in 2013. Is that still the case?

Mr Weiss: That is correct, Senator.

Senator WATT: The department also said in that inquiry that two of the licences were 2016 election commitments that the government granted without advice from the department. Is that correct?

Mr Weiss: That is correct.

Senator WATT: And you have never got to the bottom of why it was that those locations were chosen given that there was not departmental advice to support them?

Mr Weiss: They were election commitments, Senator, so the department had no input into those.

Senator WATT: I do not know if you saw this, but the minister's office told the *Caboolture Herald*—a newspaper on the northern outskirts of Brisbane—last September that the minister has requested a review on the provision of MRI licences across the country. At estimates last October, when we asked about this, the department seemed not to think that there was a formal review. What we were told was that the department was doing some

internal work. Is that still the case—there has not been a formal review; it has just been some internal work?

Ms Shakespeare: There have been parliamentary enquiries. The department certainly has been looking at MRI internally. But the department has not had an externally facing review where we have asked people to submit submissions or applications or anything, no. We have certainly reviewed inside the department and the government is currently considering its position.

Senator WATT: So what is the status of this internal work that the department is doing?

Ms Shakespeare: The government is considering policy options around MRI licences.

Senator WATT: So you have provided some policy options?

Ms Shakespeare: Yes.

Senator WATT: When was that advice provided?

Mr Weiss: We have provided advice at various stages. We provided advice in November of last year. We provided further advice in January of this year. We provided advice over more recent months as well.

Senator WATT: When was the most recent, do you know?

Mr Weiss: In the last week or so.

Senator WATT: Without getting specific about the advice, has the advice included any recommendations to the minister on expanding the number of MRI licences?

Ms Beauchamp: I do not think we are in a position to provide the nature of that advice.

Senator WATT: There would be a range of options. Do any of them include additional—

Senator McKenzie: Very good, Senator.

Senator WATT: I try.

Senator McKenzie: I know you tried to rephrase that so that you could get it.

Senator WATT: Is there an option or a live option to expand the number of Medicare MRI licences?

Ms Beauchamp: This is going to be a decision for government. We provided advice on a number of matters in relation to MRIs.

Senator WATT: That advice is still sitting with the minister?

Senator McKenzie: It is under consideration by government.

Senator WATT: So no decision has been made at this point?

Senator McKenzie: It is still sitting with government.

Senator WATT: Is there any idea when we can expect an announcement from the minister?

Ms Shakespeare: It is a matter for government.

Senator McKenzie: It is with the minister.

Senator WATT: Before or after the by-elections?

Senator McKenzie: It is sitting with the minister.

Senator WATT: Why has it taken this long? It is now eight months since the minister told the press about this review. You have been giving advice since November last year. Is there any reason it has taken this long to resolve this?

Ms Shakespeare: I think this is a complex area with very thorough advice from the department.

Senator WATT: Is part of the reason that you are not that willing to go into this that this advice is cabinet in confidence?

Ms Shakespeare: It is being considered by government.

Senator WATT: And it has gone to cabinet as well?

Senator McKenzie: I think the officer has answered your numerous questions on this piece of advice. I guess that, like everyone else, Senator Watt, you will have to wait to see what the minister has to say about the issue at the appropriate time of his choosing.

Senator WATT: Before 28 July?

Senator McKenzie: Of his choosing.

Senator WATT: Is the department aware of Labor's commitment to grant 20 new Medicare MRI licences across Australia?

Ms Shakespeare: Yes.

Senator WATT: Have you provided any advice to the government on Labor's commitment?

Ms Shakespeare: Not that I am aware of.

Senator WATT: Is anyone else aware of any?

Ms Beauchamp: I am not aware, Senator.

Senator WATT: On another topic last night, I asked about advice and was told that a factual brief had been provided on another issue. Has a factual brief been provided to the government about this announcement from Labor?

Mr Weiss: Not to my knowledge, Senator, no.

Senator WATT: The government has not requested any advice on that topic?

Ms Shakespeare: No.

Ms Beauchamp: Sorry, did you ask whether the government has requested any advice on the topic?

Senator WATT: On the topic of Labor's recent announcement.

Ms Beauchamp: Okay.

Ms Shakespeare: No.

Senator WATT: Minister, I would be very happy to show some bipartisanship. We would welcome you joining us in our commitment to expand the number of Medicare MRI licences. It is pretty clear that they are needed. I look forward to that announcement. I have one other topic here on program 4.1. This is the thing I started raising last night, but we worked out that it should be here. It is about eating disorders and new MBS items. I understand that there is some work being undertaken in relation to additional Medicare supported treatment around eating disorders.

Mr Weiss: The minister has referred that issue to the MBS Review Taskforce for advice.

Senator WATT: I see it was reported on 2 March that he referred that matter. Is that when he did make that referral?

Mr Weiss: I would need to check the exact date. It sounds—

Senator WATT: It was around then?

Mr Weiss: I would need to check.

Senator WATT: It looks like he might have announced it in a speech in early March. Are you able to confirm that a new MBS item is being considered?

Mr Weiss: I am sorry, Senator—I am advised that it was more like late last year that the referral was made to the task force.

Senator WATT: Are you able to confirm that a new MBS item is being considered in relation to eating disorders?

Mr Weiss: There is no advice in front of government at this stage.

Senator McKenzie: I have some advice. I am advised that Minister Hunt is meeting with the task force today, including members of the Butterfly Foundation, to discuss the issue.

Senator WATT: He is meeting today—right. That is to discuss the issue of—

Senator McKenzie: The Butterfly Foundation I used to work with. That is a foundation that works with particularly young women around eating disorders.

Mr Weiss: The task force has established what is called an Eating Disorders Working Group. That working group is actually meeting today.

Senator WATT: Is one of the items that they will discuss a potential new MBS item?

Senator McKenzie: They will be discussing the issue. Let us see what comes out of it.

Senator WATT: The issue of eating disorders?

Senator McKenzie: Yes.

Ms Shakespeare: The task force is independent, so it would form its own recommendations, which the government would then consider.

Senator WATT: The only reason I am asking about this is that, in the minister's speech in March, he said that he had requested that the MBS task force consider extended eating disorder treatment, including a new item of Medicare. So I do not think it is any secret that that is under consideration. I am really just seeking some sort of update on that. So work is underway?

Ms Shakespeare: It is.

Senator WATT: And it is being considered by the task force?

Ms Shakespeare: Yes.

Senator WATT: Have any costings been undertaken to determine what it would cost if a new MBS item was to be created?

Mr Weiss: There is no recommendation that has been provided to government. A costing would be done once a recommendation has been made by the task force to government. We are not at that point yet. The Eating Disorders Working Group is still considering what advice it wants to put forward to the task force. The task force will then assess that and decide

whether—as the key advisory body to the minister in relation to MBS reviews, it will assess what advice it wants to put forward or what recommendations it wants to put forward to government for government to then consider.

Senator WATT: Okay. I noticed that in that same speech in early March the minister said that, if the task force recommended a new item of Medicare, 'they have my commitment and my support that, if they propose it, we will announce this funding'. So it sounds like the minister has committed to if that is the task force's view. But no work has been undertaken to determine how much it would cost at this point?

Mr Weiss: There is no recommendation to cost at this stage.

Senator McKenzie: I think you can be assured of the minister's commitment to address eating disorders through a number of funding commitments we have made over the recent past to this particular issue. I would be watching this space with a positive mindset.

Senator WATT: The task force, I understand—it was recommended that it look into Medicare in May 2017. When was the first meeting of the Medicare task force clinical committee that is examining eating disorders?

Mr Simpson: I would have to double-check for you, but I believe it was earlier this year in February or March.

Senator WATT: I think I can put the rest of these questions on notice.

Senator DI NATALE: I am not sure if this ground was covered, but this is about the total savings from the MBS review being reinvested in the health system and specifically about the figure of $189.7 million.

Senator McKenzie: I think Senator Watt has been—

Senator DI NATALE: But specifically on that figure? Was that also addressed, Senator Watt?

Senator WATT: Yes, I asked about that.

Senator DI NATALE: Okay. Can the department break down the saving figure of $189.7 million to reflect what each MBS review recommendation it accounts for?

Ms Shakespeare: We can talk you through the areas that have contributed to that net impact.

Senator DI NATALE: But do you have—on notice if you do not have it now—the specific information about how you account for that total savings figure?

Ms Shakespeare: We can take on notice what we can provide in terms of the dollars. Would you like us to talk you through it, though?

Senator DI NATALE: Yes, that would be helpful.

Ms Shakespeare: The measures in the budget that respond to recommendations of the MBS task force include changes in the following areas: dermatology, allergy and immunology and changes to allergen testing, which will improve diagnosis of allergens in line with modern clinical guidelines. That involves restructuring allergen testing into different categories, including environmental, food and latex, medical, and anaesthetic related allergies. The task force also made some recommendations—

Senator DI NATALE: Do you have savings next to each of these?

Ms Shakespeare: We can take that on notice. These all contribute to the net figure that you mentioned before—the $189 million.

Senator DI NATALE: Yes, but you do not have them line by line next to each of these?

Ms Shakespeare: We can provide those.

Senator DI NATALE: Thank you. So specifically—

Ms Shakespeare: Do you want them on notice?

Senator DI NATALE: Do you have them here?

Ms Shakespeare: We will take them on notice, but I can talk you through the areas.

Senator DI NATALE: Okay, but just to be clear so that there is no confusion with the information you are taking on notice, you will be able to provide me with the line-by-line breakdowns for the estimated savings in each—

Ms Shakespeare: For the areas.

Senator DI NATALE: In each—

Ms Shakespeare: They are not necessarily estimated savings. They are impacts on Medicare expenditure.

Senator DI NATALE: Yes. Well, that is splitting hairs, but you will be able to tell me—

Ms Shakespeare: We have had a long discussion this morning. The MBS is actually growing, and growing quite strongly over the forward estimates.

Senator DI NATALE: Yes. Again, I am not somebody who argues against this process. I think that, providing the money is reinvested back into health care, it is a good and sensible use of the department's time. So there was allergen testing?

Ms Shakespeare: Also in the area of dermatology, there was allergen immunology. The task force identified that there were a lot of whole-body cabinet phototherapy or light treatment services being provided. Some restrictions have been introduced there to restrict the number of those services that people might have in the course of a year so that it does not have detrimental impacts on their skin. Also, there are changes to the item for removal of cancerous lesions. That is consolidating the existing separate item for the removal of 10 or more lesions at once. The task force was concerned that people might have been having too many lesions—

Senator DI NATALE: Yes.

Ms Shakespeare: There are changes in the area of diagnostic imaging and the introduction of a new interim item for three-dimensional breast tomosynthesis, which is 3D breast imaging. This is under assessment by MPAC, but the task force recommended the interim items because these services are now being provided and were being claimed under a different MBS item. There is the removal of the requirement for children or people under the age of 16 to have an X-ray before they are able to have an MRI. The task force was concerned that people might have been exposed to unnecessary X-rays. There are restrictions on the ability of GPs to request knee MRIs for people over the age of 50. There are changes in the area of diagnostics—

Senator McKenzie: Just on that, Ms Shakespeare, it is not cancelling MRIs on knees—it is reducing the number. How many were there per year?

Ms Shakespeare: There were a couple of changes to the GP requesting items. At the moment specialists are restricted to three requests per person for MRIs. A similar request—

Senator McKenzie: Per year.

Ms Shakespeare: has been introduced for GPs per person but also—

Senator DI NATALE: Was that three?

Ms Shakespeare: For people under the age of 50, GPs will be restricted to requesting three MRIs per person per year, which is equivalent to specialists.

Senator DI NATALE: Three MRIs. You are taking about generally? You were talking about knees before.

Ms Shakespeare: No, that is knee MRIs.

Senator DI NATALE: Why would you need more than three MRIs per year anyway?

Senator McKenzie: Exactly. Good point.

Ms Shakespeare: There are changes to diagnostic procedures for thoracic medicine. We are hoping to improve diagnosis of asthma in general practice through changes to spirometry items to encourage greater use of those tests. There is a new structure for sleep study items to ensure better identification and management of patients with sleep disorders. There is a new set of items to support complex lung function tests to reflect the complexity of those tests. There are changes to renal medicine, including a new item being introduced to support the delivery of dialysis in very remote areas, which will improve access for Aboriginal and Torres Strait Islander people to those services. These are 'on behalf of' items.

Senator DI NATALE: That is not a saving—that is going to be an additional expense.

Ms Shakespeare: These items are changes. Some result in additional expenditure and some result in reductions in expenditure.

Senator DI NATALE: Okay.

Ms Shakespeare: So, yes, that will certainly result in an increase in expenditure. I am happy to tell you what that is on notice. We can break that down. But that is to give nurses, Aboriginal health practitioners and workers 'on behalf of' items so they can support those services. There are some other minor changes to renal items—changes to item descriptions and removal of an item for the insertion of a temporary catheter for peritoneal dialysis. The spinal surgery schedule has been modernised reflecting contemporary practice and removing three obsolete items and clarifying that spinal fusion must not be performed or claimed under the MBS for the treatment of uncomplicated axial chronic lower back pain. There are also some changes to the capsule endoscopy item. The fee for this procedure will be reduced to reflect the current costs of providing that service. There is a modernisation of the schedule for endocrinology. Again, that is reflecting contemporary clinical practice, encouraging thyroid removal when treating overactive thyroid, amending parathyroid surgery items to promote best practice and restructuring adrenal gland surgery items. So those changes will be reflected in the MBS from 1 November. There were also some changes in the budget associated with trans-vaginal mesh products in pelvic organ prolapse surgery, which responded—the task force is still considering its final recommendations on gynaecology, but the government has moved to implement recommendations on an interim basis to reflect changes at the TGA and the registration of those products on the ARTG.

Senator DI NATALE: That is the comprehensive list. I think a couple of other areas that have been discussed previously were knee arthroscopies. Are there any changes in that space?

Ms Shakespeare: That is this budget's changes. I am not sure that we have—

Senator DI NATALE: Any updates on that?

Mr Weiss: No. I think Ms Shakespeare has run you through everything that contributes to the $189.7 million.

Senator DI NATALE: Okay, but you have not got any updates on any proposed changes at this stage?

Ms Shakespeare: There are other recommendations that have been made by the task force to the government. There are currently 11 that are under consideration. There are more task force areas of review where they have not made recommendations to government. So there will certainly be more recommendations coming forward and more government responses to those over time.

Senator DI NATALE: So you feel this was sort of the low-hanging fruit, as it were—some of the easier stuff where there was consensus achieved earlier on?

Ms Shakespeare: The low-hanging fruit probably best characterises the obsolete items removed in 2016-17, I think. These are the product of a lot of work by the task force in consultation with—I think we have had over 500 clinicians, consumers and health economists involved.

Senator DI NATALE: Yes, I am aware of that.

Mr Weiss: It has been worked through in a sequenced way. These were the ones that were essentially ready to go for the budget.

Senator DI NATALE: That is good. I look forward to getting that information on notice.

Senator DEAN SMITH: I just wanted to turn to the issue of bulk-billing rates. I am starting at a high level. Why is it that we use bulk-billing rates as a demonstration of success of access to the healthcare system?

Ms Shakespeare: It is used as an indicator of the proportion of services that are being provided to patients at the MBS schedule rates, so there is no additional cost to patients. So I suppose it is a good indicator of affordability and universal access to health services under Medicare.

Senator DEAN SMITH: How often have we been using bulk-billing rates as a demonstration of affordability and access?

Ms Shakespeare: We have quarterly updates—

Senator DEAN SMITH: I mean historically—how often have we been using bulk-billing rates as a measure?

Ms Shakespeare: I think we have been measuring them for a long time—certainly since I have been in the department, and that is a long time.

Senator DEAN SMITH: Starting at a high level, can you give us a picture of what is the bulk-billing rate experience across the country?

Ms Shakespeare: With bulk-billing rates generally the key measure is GP non-referred attendances. But we also measure bulk-billing across all services covered by the MBS. Bulk-

billing rates continue to increase. For the last quarter the data shows—that is the July to March quarter—that 85.8 per cent of the GP non-referred attendances are bulk-billed.

Senator DEAN SMITH: How does that compare historically?

Ms Shakespeare: That compares to 85.4 per cent for the same period last year, so that is a 0.4 percentage point increase.

Senator DEAN SMITH:

Is that the highest bulk-billing rate we have seen or is it the highest bulk-billing rate you have seen?

Ms Shakespeare: Yes, for non-referred attendances.

Senator SMITH: Can you give us a bit of a state-by-state snapshot?

Ms Shakespeare: Again, for non-referred attendances—GP services—in New South Wales the year-to-date number for July to March 2017-18, 88.7 per cent of services were bulk-billed. In Victoria 85.1 per cent of services were bulk-billed. In Queensland 85.7 per cent. In South Australia, 84.6 per cent. In Western Australia, 83.6 per cent. In Tasmania, 75.9 per cent. In the Northern Territory, 89.6 per cent. In the ACT, 61.9 per cent. That contributes to the national average of 85.8 per cent.

Senator DEAN SMITH: How does that national average of 85.8 per cent compare to the last period or same period under the previous Labor government?

Mr Weiss: I have data going back a few years, Senator. I am trying to think which year that would exactly apply to. I have here for 2013-14.

Senator DEAN SMITH: 2012-13 would be–

Mr Weiss: For the corresponding period, July to March 2012-13, the bulk-billing rate for GP non-referred attendances was 82.0 per cent.

Senator DEAN SMITH: So that is a positive difference of 3.8 per cent?

Mr Weiss: It is 3.8 percentage points.

Senator DEAN SMITH: What does that mean in terms of numbers of services? It is 3.8 per cent, but what is the quantum of additional services that are being accessed?

Mr Weiss: To give you a sense of scale, in 2016-17 there were around 150 million GP consultations, so one percentage point of that is 1½ million consultations. So 3.8 percentage points would be getting close to six million consultations just on the maths in my head. But that is—to give a sense of scale, they are large numbers.

Senator DEAN SMITH: Excellent. Before I go to the metro, non-metro and regional picture, the disparity or the differences between bulk-billing rates between states and territories—what are some of the reasons or explanations for that?

Ms Shakespeare: I suppose it will depend on the competition in the GP workforce. One of the lowest bulk billing rates is in the ACT. It would be a factor of both the number of GPs available to people in the ACT and those doctors' assessment of the capacity of their patients to pay above the Medicare Benefits Schedule fee.

Senator DEAN SMITH: Can you give me a sense of what the bulk-billing experience is in the inner regional compared to outer regional, remote and very remote? Do you collect that breakdown?

Ms Shakespeare: Yes.

Mr Weiss: We do, Senator. This is total Medicare services rather than the GP services we have been talking about to date.

Senator DEAN SMITH: Why can't we talk about—why can't we use the same comparator?

Ms Shakespeare: We do have those figures here as well. The bulk-billing rate by remoteness area for GP non-referred attendances for the 2017-18 year to date for the March quarter was: major cities, 86.7 per cent; inner regional, 83.2 per cent; outer regional, 84.0 per cent; remote, 84.1 per cent; very remote, 89.2 per cent. There is also an unknown remoteness category. I am not sure why. But that is 85.3 per cent.

Senator DEAN SMITH: What is an unknown remote—

Mr Weiss: I think there are services where the system just cannot identify where the patient is from. So there is a very low number of services that fit into that.

Senator DEAN SMITH: You would hope so. This is my last question. Do you have comparative figures for the period 2012-13?

Ms Shakespeare: By remoteness area?

Senator DEAN SMITH: Yes.

Ms Shakespeare: In 2012-13 for the same year to date—the July to March period—for major cities it was 83.0 per cent; inner regional, 78.9 per cent; outer regional, 79.9 per cent; remote, 80.9 per cent; very remote, 86.4 per cent; and unknown remote, 77.6 per cent. That is all of the categories.

Senator DEAN SMITH: On my quick maths there has been a three per cent improvement in the bulk-billing rate in the period from 2012-13 to 2017-18 of about three per cent for inner regional. There has been an improvement in the bulk-billing rate in the period 2012-13 to 2017-18 of about four per cent and there has been an improvement in the bulk-billing rate for remote for the period 2012-13 to 2017-18 again of about four per cent and for very remote the bulk-billing rate has increased from 86.4 per cent to 89.2 per cent, so that is an improvement of about 2.5 per cent or thereabouts. So the experience of this government compared to the same period of the last government is positive when it comes to improvements in bulk-billing rates?

Ms Shakespeare: Bulk-billing rates have increased.

Senator DEAN SMITH: Thank you.

CHAIR: That ends program 4.1. We will move on to program 4.2: Hearing Services.

Senator SINGH: I understand that the government is yet to respond to the inquiry into hearing health and wellbeing Australia report. I wanted to ask what the status of that was—of the government response to the inquiry. We are still kind of waiting to be heard, pardon the pun.

Ms Buffinton: The government is yet to respond. It has been reasonably complex, as you can appreciate. It was not just one department. The inquiry and the recommendations covered quite a range of departments, including Jobs, Social Services, et cetera. We have now just been finalising the coordination of that and providing advice to government.

Senator SINGH: What is the time frame we are talking about?

Dr Studdert: It will ultimately be a matter for the minister and the government. But, as Ms Buffinton has explained, it is a complex task ranging across quite a few agencies and departments. But we are in the final stages of preparing that response. Obviously it needs to be considered by the minister. It would not be possible to commit to any particular timeline. I note that Minister White has at the same time been working quite closely with the sector and stakeholders on a range of roundtables and discussions on a roadmap for hearing health. So there is work already underway in terms of how we will move forward in this space.

Senator SINGH: It has been I think six months or more. It was September last year, wasn't it, when this—

Dr Studdert: Correct—it was 13 September. I hate to say that it is not unusual, especially when we have to consult across many parts of government.

Senator SINGH: I just do not understand why the government has failed to respond but why also today here at estimates you cannot actually give me any kind of time frame. Are we going to be waiting another six months? It is an important body of work that government needs to respond to.

Ms Beauchamp: I think Dr Studdert has already commented on that. It is not as if the government is failing to respond. We are actually providing advice and working across agencies to develop a whole-of-government response. The government and indeed the minister will respond as soon as possible.

Senator SINGH: Has a decision been made on the contestability of hearing services for children?

Ms Buffinton: In terms of hearing services for children, that comes under the community service obligation part of the Hearing Services program. That is administered by Australian Hearing, which is in the Human Services portfolio. There has been a Productivity Commission report, however. The Australian Government Competitive Neutrality Complaints Office under the Productivity Commission has been looking into Australian Hearing and they provided a report last week.

Senator SINGH: Has that been made public?

Ms Buffinton: Yes, it has.

Senator SINGH: What is happening with the Community Service Obligations program clients that do not transfer to the NDIS?

Mr Morgan: At present we have around 1,834 people under the Hearing Services Program who are NDIS participants—849 of those are CSO clients and the remainder are voucher clients. We have also been working with the NDIA. They have provided a request under their legislation to identify clients who we believe are eligible for NDIS who are currently under the Hearing Services Program.

Senator SINGH: How many?

Mr Morgan: We estimate around 34,000 CSO clients and around 9,000 voucher clients will be eligible. But as of today I think only around 1,800 have signed up.

Senator SINGH: That is quite an increase—

Mr Morgan: Needs to happen.

Senator SINGH: that would be eligible, yes. Is there any communication problem with those clients to make them aware of that eligibility?

Mr Morgan: There will be. That is really a question for the NDIA around their communication with those clients. But the first step was to identify the clients, pass that information to the NDIA and work with them around the communications. So we will be doing that.

Senator SINGH: Can you let me know what Professor Hugh Taylor's involvement in the development of the ear health road map is?

Ms Buffinton: As far as the hearing health road map that the minister has announced, he is currently considering who will be part of that committee. At this stage, the minister has not announced any members of the sector committee that he will be establishing in order to develop the hearing health road map.

Senator SINGH: So you cannot say whether Professor Hugh Taylor will be on that sector committee?

Ms Buffinton: The minister has not finalised who is going to be on that committee.

Senator SINGH: Does Professor Hugh Taylor have any involvement in the ear health road map?

Dr Studdert: Professor Taylor is a very eminent physician, and a specialist particularly in eye health, but he has worked for a long time in Indigenous communities. We know that there are significant problems with hearing health among young people in Indigenous communities. I suspect he, amongst many people, has talked to the minister about the issues—the environmental issues and the health services issues. As I mentioned earlier, the minister has had a range of discussions and roundtables with experts. I believe that Professor Taylor was—I do not have the attendance list of those, but I believe he may have been involved in some of those.

Senator SINGH: This sector committee—do you provide names or do you advise the minister?

Dr Studdert: We talk with the minister's office and with the minister. I learn from the minister who he is talking to and who he is interested in involving. Of course, we also scan our own networks and stakeholder forums for a list of experts and provide advice about the options that the minister has. But, ultimately, as Ms Buffinton said, it is a decision for the minister.

Senator SINGH: But have you done that yet?

Dr Studdert: We are putting together that advice at the present.

Senator SINGH: On that, what are the intended objectives of this ear health roadmap?

Dr Studdert: I think the minister—indeed, all of us have a range of recommendations and advice from a number of reviews. The minister would really like to pull that all together to work collaboratively with the stakeholders to develop a common vision of how we are going to move forward across the department, and the various parts of it that work in this space, as well as across the sector and the various communities and interest groups that have a role and, indeed, a vested interest in getting some better and more coordinated service delivery.

Senator SINGH: So have there been terms of reference set? Is there a time frame?

Dr Studdert: That is all part of the advice we are putting together. I think the minister is keen to start as soon as possible. We are really very much in the final stages of putting that advice together for the minister. But I know that he would like to have something prepared by the end of the year, I think he said. So we are going to have to work hard and fast.

Senator SINGH: Is that the end of the financial year or the end of the calendar year?

Dr Studdert: The end of the calendar year.

Senator SINGH: And something prepared as in what?

Dr Studdert: As in a road map, which is the intention of the work of the group.

Senator SINGH: Right, so you have from now until—there has been obviously the tabled report from September last year. Little detail is available about this road map—

Dr Studdert: That is because that is to be worked out.

Senator SINGH: And you have from now until the end of this year to come up with everything?

Dr Studdert: I think there is a lot of advice and issues to bring together. In fact it is a relatively short time frame. But, as I indicated, the minister is very intent on delivering to that.

Senator SINGH: Are any consultations planned?

Dr Studdert: There is no specific detail, but I very much anticipate that will be part of the process, though.

Senator SINGH: Will this hearing health road map be the government's response to the hearing health report? Is that what this is?

Dr Studdert: No, that will be a process.

Senator SINGH: The government announced in the budget $30 million for hearing health assessments. What is the implementation plan around that?

Mr Morgan: That is being looked after by the Indigenous health area. To be honest, I do not have the details on me now, but that would be a question for the Indigenous area. That is the screening.

Senator SINGH: Is the Indigenous area here to answer those questions?

Dr Studdert: Those estimates were last Friday, but we do—

Ms Beauchamp: I think we said we were going to have people available today, because I think there was a request yesterday.

Senator SINGH: I guess I am interested to know how the government will deliver this new targeted outreach program in the states and territories.

Dr Studdert: I think that is a question you will have to direct to my colleagues.

Ms Edwards: Can you repeat the question, please?

Senator SINGH: The question was about the $30 million in the budget for hearing health assessments. I was wondering what the implementation plan is around that, particularly how the government will deliver the new targeted outreach program to the states and territories. It is about that outreach program model.

Ms Edwards: The $30 million in hearing health assessments is really for a screening program for children before they reach school. So it is a new capacity to pay for the screening. Exactly how it is to be delivered is something that we are working out.

Senator SINGH: Do you know if it has been agreed upon—this outreach model—by the Australian Health Ministers' Advisory Council? Have the states and territories come on board?

Ms Edwards: It is a Commonwealth government initiative, but it is in the context of work being done through AHMAC on Indigenous ear health, and certainly consistent with all of those directions. But it is a Commonwealth government initiative.

Senator SINGH: I know that it is a Commonwealth government initiative, but I am seeing if the AHMAC have agreed—

Ms Edwards: It is consistent with the work that is being done through AHMAC, but it is not an AHMAC initiative.

Senator SINGH: But have the state and territory ministers agreed to it? Have they come on board?

Ms Edwards: To my knowledge this specific initiative has not been discussed with AHMAC at this point, but it is consistent with discussions.

Senator SINGH: I am just wondering where the first 18,000 children will receive these assessments. Will it be at school or—I think you said preschool, didn't you?

Ms Edwards: It would be before school. It is zero to six. The program is expected to commence in the first quarter of 2018-19. We are currently working with the Indigenous health sector and other key stakeholders, including Australian Hearing, to finalise the implementation arrangements.

Senator SINGH: Okay. So in the next financial year?

Ms Edwards: Correct.

Senator SINGH: Okay. Do you know what the profile of the $30 million is as far as the allocation by activity?

Ms Edwards: In years? Do you mean in which years, Senator?

Senator SINGH: The location.

Ms Edwards: No, I would have to take that on notice. I suspect it has not yet been determined. It is something we are working through with the sector.

Senator SINGH: How much will the ACCHOs get to deliver the assessments?

Ms Edwards: I cannot answer that in specifics, other than to say that we are working with the Aboriginal-controlled health sector about how it is to move forward.

Senator SIEWERT: So as I understand it, there are 18,000 in the original—

Ms Edwards: Up to 18,000 children are to receive an assessment in the first year.

Senator SIEWERT: And then it is a rolling process after that?

Ms Edwards: That is my understanding.

Senator SIEWERT: Then what happens once they have had their hearing assessed? It is something—you are probably aware—that has been going on for a long time.

Ms Edwards: There is further funding out of the Indigenous health program for a range of activities to improve ear health—so that access to clinical services. So we are really committed to making sure the assessments happen and then they lead to whatever activity has to happen.

Senator SIEWERT: That is what I wanted to know.

Ms Edwards: The other clinical services being funded through the program, which will complement the work of the assessments, are: surgery, equipment, trained health professionals, and also the work we have underway to link up to make sure that the assessments lead to appropriate referrals. But I do not have the detail of it here with me today.

Senator SIEWERT: Before we go to appropriate referrals, can I just ask about sound fields as well? In talking about appropriate responses, we have discussed in the past sound fields in classrooms, and we still do not have them rolled out in all of the appropriate locations. Is that considered a response as well?

Ms Edwards: I would have to take that on notice. The relevant people are not here today. I can assure you that we are really committed to making sure that the assessments lead to an appropriate response. Exactly what the details of that are, either I am not aware of them or they have not been resolved yet.

Senator SIEWERT: Can you take that on notice?

Ms Edwards: I will take that on notice—the sound fields.

Senator SIEWERT: Yes. The other issue is catching them up in terms of literacy and numeracy programs. One of the key areas here is not just addressing their hearing but also the development they have missed out on during to their hearing loss. Is that going to be ramped up as well, once we have identified in the assessment what their functional capacity is due to hearing loss?

Ms Edwards: I appreciate the issue. Educational catch-up and related issues are not within our direct scope, but it is something we are dealing with other departments about and we will be talking to them. In the context of social determinants and the work on Closing the Gap we will talk to Education and others about that, but it is not directly within our sphere of activity.

Senator SIEWERT: I understand what you have just said, that it relates to Education. But this is the issue with silo approaches. Is there a responsible agency—or is it PM&C—that is responsible for then looking at how that goes into the Closing the Gap Refresh? I am aware of the refresh program. It is running. But in the meantime you have this program going, which is good—I am not complaining. But then who is the responsible coordinating agency? To make sure that those other bits and pieces bolt on, to make sure that these kids—addressing the hearing loss is only part of the answer here.

Ms Edwards: I would be going to PM&C first to ask that question, because I would not want to be definitive about whose responsibility it is. We would have to direct that to them.

Senator SIEWERT: So I should ask PM&C.

Ms Edwards: One of the key things about this is that, because it is directed at zero to six, we are hoping to minimise—obviously, there is massive development before age six but, as to the schooling aspect of it, it is to try to resolve hearing issues before school.

Senator SIEWERT: Yes, I understand that, but the problem is that the work shows that zero to six is a critical time. We already know their development will have been affected. So just fixing the hearing loss—I absolutely agree that it is essential, but unless we do that catch-up work we are not going to fix up the issue once they hit school, because they will not have that basic literacy and numeracy that other kids have. That is what the evidence shows.

Ms Edwards: I understand the issue. We can take on notice what complementary activities are happening in other departments and pass it to them.

Senator SIEWERT: That would be great. Thank you.

[10:46]

CHAIR: We will finish program 4.2 and move on to program 4.3, Pharmaceutical Benefits.

Senator DI NATALE: Can I first go to the government's response to the King review of pharmacy. Can I ask, firstly, what information the government has with regard to cost structures of pharmacies. I could perhaps go more specifically to evidence about the relative efficiency of the different types of ownership, for example.

Ms Shakespeare: The government would have information about dispensing remuneration paid to pharmacies by the government. I think the information we have about the cost structures of different types of pharmacies would be fairly limited. In fact, that was something that was identified in the review—that there was not that much information available.

Senator DI NATALE: Is there any attempt to change that given that it is a relevant factor, I suppose?

Ms Shakespeare: The review recommended that the government seek more information and that is something that we will be discussing with pharmacy.

Senator DI NATALE: What does that look like? What does that mean, getting more information?

Ms Shakespeare: I believe that recommendation is one that has been noted by the government.

Senator DI NATALE: Yes. What does that mean?

Ms Shakespeare: We will continue working on it in partnership with pharmacy.

Senator DI NATALE: Can you be more specific?

Ms Shakespeare: We will have discussions with them about the sorts of information that they would be willing to share with us.

Senator DI NATALE: Are you going to seek that information?

Ms Shakespeare: We are very happy to seek that information, and I am sure that we will. Whether or not—

Senator DI NATALE: You are sure that you will. Okay. So the short answer is yes?

Ms Shakespeare: Yes, but the extent of the information that we are able to access is something that we need to discuss with pharmacy.

Senator DI NATALE: I understand that, but the intent of the department is to seek that information—that is all I am asking.

Ms Shakespeare: Yes.

Senator DI NATALE: You do not really use that information when you are setting pharmacy remuneration—that is not a factor in terms of negotiating agreements?

Ms Shakespeare: When we negotiate agreements we would have discussions with pharmacy on a range of different things—pharmacy programs, pharmacy dispensing, remuneration, their costs, and pressures on the industry—so yes.

Senator DI NATALE: Just to confirm, the government rejected the recommendations from the King review about setting remuneration based on best-practice pharmacy. Is that right?

Ms Quaine: There were four recommendations; three recommendations that were rejected. The government did not support the abolition of the $1 discount policy. It did not support machine dispensing. It did not support changing arrangements for the pricing and supply of generic medicines because of the current effectiveness of price disclosure arrangements.

Senator DI NATALE: So was that noted then, that recommendation?

Ms Quaine: That recommendation that you mentioned—can you say that again?

Senator DI NATALE: It was about setting remuneration based on best-practice pharmacy. I am assuming that was about the different types of ownership in practice.

Ms Shakespeare: That is recommendation 5.2. It was noted.

Senator DI NATALE: It was noted but not rejected?

Ms Shakespeare: Yes. There were only three recommendations that were—

Senator DI NATALE: Those three that you outlined—okay. In terms of the ones that are noted, what does the status of 'noted' actually mean?

Ms Quaine: I think at the beginning of the response it does say that the government notes a number of recommendations of the review that complement work that has already been undertaken or is in progress. It notes also that the recommendations of the review require further investigation by government. We are currently more than halfway through the current agreement—the Sixth Community Pharmacy Agreement. The current agreement outlines when we would need to commence negotiations for the new agreement, which is July next year. So there are a number of recommendations that we would need to be looking at in the context of that new agreement.

Senator DI NATALE: I could pursue that. Noting something does not mean you are going to continue to work on it. You have 'rejected' some outright, and we know what that means. But does noting something mean that you are going to seek more information or continue to advance that recommendation in some way?

Ms Quaine: Yes, in the context of developing the new agreement. We would be looking at the review and the recommendations that have been noted by government in order to develop the government's position on the seventh agreement.

Senator DI NATALE: There was a recommendation about section 100 for the Remote Area Aboriginal Health Services Program and the Closing the Gap PBS co-payment. I think you identified some policy and implementation issues. What were they?

Ms Quaine: Yes. There has actually been a broader review of those programs. There are two main programs—the section 100 program, which provides medicine to Aboriginal and Torres Strait Islander people in remote areas. That is pharmaceuticals provided in bulk by community pharmacy to remote area health services. People are provided with those medicines without the requirement for a prescription or a co-payment. Then there is the Closing the Gap program, in which the co-payment is reduced for Aboriginal and Torres Strait Islander people. That tends not to operate in rural areas. That broader review had similar recommendations to the King review or the Review of Pharmacy Remuneration and Regulation.

Senator DI NATALE: Basically it should be accessible to all Aboriginal—

Ms Quaine: It should be accessible irrespective of where the person lives.

Senator DI NATALE: That is right.

Ms Quaine: There is a number of legislative system and funding issues associated with those recommendations, but we are actively looking at those at the moment. We have recently circulated the report on the review—not the Review of Pharmacy Remuneration and Regulation, because at the same time as doing the Review of Pharmacy Remuneration and Regulation there was a specific review of all of the programs under the Sixth Community Pharmacy Agreement. That review of the Indigenous programs was undertaken and that report has just recently been circulated to stakeholders with a view to working with stakeholders for implementation of some of those arrangements.

Senator DI NATALE: What are the legislative barriers?

Ms Quaine: For example, the section 100 program is a legislative program, so if there were any changes we would have to look at what legislative changes we would need to make.

Senator DI NATALE: Would there need to be? Are you confident that you would need to change—

Ms Quaine: They are the sorts of things that we need to look at in detail. In terms of payment arrangements, for example, the payment arrangements under the PBS are very fixed and associated with the legislative arrangements, so DHS payment systems are set to align with legislation. Often we need IT changes for the DHS system to allow the payments to be made or any changes to payments to be made. Then there is also the issue of ensuring that we have enough funds to undertake any changes.

Senator DI NATALE: Sure. I suppose that is one of the issues that is probably a question for government.

Ms Quaine: Yes.

Senator DI NATALE: But can I take it that the intent of the department is to work through those issues and acknowledge that two reviews now have recommended similar things—that Aboriginal and Torres Strait Islander people get access to medicines under both of those programs—and that you are looking actively at how to facilitate those recommendations? Is that a fair summary?

Ms Quaine: Yes, we are actively looking at how to implement those recommendations.

Ms Shakespeare: I think the reviews are recommending that we take a broader approach to make sure all of the various programs to support access to pharmaceuticals by Aboriginal and Torres Strait Islander people are working together and we do not have barriers in access caused by the way particular programs have been designed. I think what we need to do here is really a piece of co-design work with people in the community to come up with replacement arrangements that are going to work better for everybody.

Senator DI NATALE: Just with regard to the seventh agreement, there was always this discussion about who is involved. Is the Pharmaceutical Society going to be involved in the negotiation and in what capacity?

Ms Shakespeare: The negotiations will not be starting for over another year and we are not really in a position to tell you how they will be conducted.

Senator DI NATALE: You have not turned your mind to that despite the fact that, obviously, that has been a key issue in previous negotiations?

Ms Shakespeare: Every agreement is different. We have not started work on this one yet.

Senator DI NATALE: On the PBS in particular, the budget has $1 billion in contingencies for new PBS listings. Is that right?

Ms Shakespeare: There is a provision, which has been referenced I think in Budget Paper No. 1, of $1 billion which will be available for new PBS listings that will come out of PBAC recommendations.

Senator DI NATALE: In the budget item 'Improving Access to Medicines—additional funding for new medicines and improved payment administration', which looks a lot like a savings measure, am I right in saying that the—

Ms Shakespeare: It is not. It is not a savings measure.

Senator DI NATALE: So you are committing an additional $1 billion in new listings?

Ms Shakespeare: There is a provision for $1 billion for new listings, which has been made available by the government. It has not appeared in the forward estimates yet because we do not know which medicines it will be spent on yet or when they will be listed.

Senator DI NATALE: Does that mean that once a medicine is recommended for listing by PBAC that it is not going to have to go to cabinet? As a result of that contingency, do you expect that that money will be forthcoming?

Ms Shakespeare: Government decision-making processes are a matter for government.

Senator DI NATALE: Can the government confirm this, Senator McKenzie? Once medicines are recommended for listing, given that there is now this contingency, they will be listed as soon as that recommendation occurs—or is that still going to be a decision that requires cabinet approval?

Senator McKenzie: I will have to consult with the minister on that, but I note that everything that has been recommended for listing since we have come to government has become available on the PBS, which is a fantastic outcome for access to up-to-date medicines for the Australian public.

Senator DI NATALE: Will you take that on notice?

Senator McKenzie: Yes.

Senator DI NATALE: The department hired KPMG to work on efficiency improvement options for the PBS process. Is that right?

Ms Platona: That is correct. Out of the agreement with Medicines Australia there has been work on streamlining PBAC processes. That work is led by the department and Medicines Australia and supported by KPMG.

Senator DI NATALE: What does streamlining actually mean? Can you provide us with any updates?

Ms Platona: Everything about PBAC is not straightforward, as you know. What we are looking at is a number of objectives and greater engagement with pharmaceutical companies as part of their pre-submission meetings with the department in order to have better planning capacity for the department. We are also looking at—what is a rather inelegant word—resubmission churn. That means that applications go through a first rejection, then another resubmission and then another resubmission. What we are trying to do there is find a way to cut through really what is sometimes price negotiation via a submission to the PBAC and finding some ways to streamline the machinery of application and outcomes from the PBAC. The third part of it is a process matter that happens after PBAC has made a positive recommendation. There are a number of processes there that PBAC is not involved in but the department and the pharmaceutical company works as best as it can on, sometimes quickly, but sometimes more complex issues emerge on price negotiations, establishing the restriction that the PBAC has imposed as part of the recommendation, the re-sharing arrangements, costings and so on. Those processes also involve other agencies, the Department of Human Services and the Department of Veterans' Affairs. So the end-to-end planning and working that involves PBAC and post-PBAC processes are all part of this project.

Senator DI NATALE: When do you expect to be able to announce the outcome of that?

Ms Platona: The agreement with Medicines Australia requests that the department and Medicines Australia, as a joint project, report to the minister by July, and we intend to do that. Then it will be a matter for the minister.

Proceedings suspended from 11:01 to 11:20

CHAIR: We will resume. We are continuing on program 4.3: Pharmaceutical Benefits.

Senator GRIFF: I understand that PBAC was directed by the minister to develop a process for assessing pan-tumour medicines. What stage is that process actually at at the moment?

Ms Shakespeare: The Pharmaceutical Benefits Advisory Committee has decided to hold a special meeting in August this year to consider the matter further. There has also been a paper that has been circulated before that meeting and I think an invitation for views to be put forward by interested stakeholders.

Senator GRIFF: Why has PBAC spent a year really not doing much apart from perhaps the paper except for deciding to hold the meeting in August?

Ms Shakespeare: That is not all that it has—the PBAC has also had discussions about this matter internal to the committee. But they have decided that they need to have further

consideration, including the views of stakeholders, and they have established a process that it is fair and transparent for those views to be collected.

Senator GRIFF: So the August meeting is to review that—

Ms Shakespeare: The external feedback to PBAC.

Ms Platona: The paper that PBAC has issued is publicly available. It was made public on 21 May. The committee will consider all of the input from all interested stakeholders. So far we think we are going to have at least 40 to 50 industry parties that will contribute to the discussions of PBAC in August.

Senator GRIFF: Thank you. I would like to now ask a few questions in relation to pharmacies. Does the department actually undertake any auditing of pharmacists or pharmacies or is this left to AHPRA and the national boards?

Ms Shakespeare: It depends on what you mean by auditing. Certainly, we have a compliance function which looks at the billing of the Pharmaceutical Benefits Scheme by pharmacists.

Senator GRIFF: The government accepted recommendations 2-5 of the Review of Pharmacy Remuneration and Regulation. That recommendation stated that 'The Pharmaceutical Society of Australia guidelines and the distribution of Consumer Medicines Information to consumers should be audited and enforced to ensure compliance'. The department itself does not undertake any in-house auditing as such?

Ms Shakespeare: Certainly we have a compliance function that looks at the costs to the PBS billed by pharmacists.

Senator GRIFF: So you are actually auditing pharmacies and pharmacists or are you just looking at the costs?

Ms Shakespeare: It is PBS expenditure and the way that we also audit providers who bill services to the MBS. We have the area available to answer questions about compliance I think under outcome 4.7.

Ms Platona: Senator, may I ask which particular recommendation you are referring to?

Senator GRIFF: It is the Review of Pharmacy Remuneration and Regulation—that recommendation that stated that they should be audited and enforced to ensure compliance. Are many pharmacies currently registered to participate in the MedsCheck program?

Ms Shakespeare: Yes, Senator.

Senator GRIFF: Can you provide the number of pharmacies that are registered?

Ms Quaine: I think we would have to take that on notice.

Ms Shakespeare: Those programs are administered by the Pharmacy Guild on behalf the government, so we would probably need to seek the information from them.

Senator GRIFF: How much per year is spent on MedsCheck?

Ms Quaine: Under the Sixth Community Pharmacy Agreement there is $1,263 million spent over the five years from 2015 to 2020 on community pharmacy programs. I do not have the particular figures on MedsCheck with me. I would need to take that on notice.

Senator GRIFF: Could you also on notice provide me with information over the last three years as to whether the increases—I am sorry, whether the cost is constant, has increased or has decreased?

Ms Quaine: I can tell you that we did increase the number of MedsChecks that pharmacies are able to provide. There was an additional $600 million approved by the government under the Sixth Community Pharmacy Agreement in the context of the 2017-18 budget. That went to expanding both the MedsCheck and the Diabetes MedsCheck programs. There was $900 million allocated over the three years for the extension of those programs.

Senator GRIFF: I also understand that MedsCheck is not available—

Ms Quaine: I am sorry—that was $90 million.

Senator GRIFF: I thought $900 million was pretty impressive. My understanding is that MedsCheck is not available to clients that have already had a MedsCheck in the previous 12 months. Is that correct?

Ms Quaine: There are program rules that govern how often someone can have a MedsCheck. But, with the revised MedsCheck, we have actually built in review steps. Also, there is a proportion of patients for whom we are actually assessing the health outcomes associated with the MedsCheck. We are using that information to inform ourselves about the effectiveness and cost-effectiveness of the programs. We would be looking at that in the consideration of the next agreement.

Senator GRIFF: If a person experiences a significant medical event within a year of having a MedsCheck, are they on their own or does the pharmacist's duty of care mean that their circumstances would be assessed as would normally happen with a MedsCheck?

Ms Quaine: If a patient is still accessing a community pharmacist and accessing medicines, the pharmacist certainly does have a professional obligation to answer any of their questions about the medicines or discuss any issues they are having in terms of side-effects. That is part of the pharmacist's normal professional practice. If they have actually had a MedsCheck and they are not eligible to have another one within a particular time frame, that is one issue, but it does not mean they do not have access to any professional support.

Senator GRIFF: Does this mean that also pharmacists who participate in MedsCheck are effectively being paid extra to do a job that they should already be doing as part of their responsibilities?

Ms Quaine: No, I think the MedsCheck is over and above the normal professional practice of a pharmacist.

Senator GRIFF: Has the department undertaken any auditing in relation to MedsCheck and in relation to pharmacies and pharmacists?

Ms Shakespeare: We did agree with the pharmacy profession last year, as part of the changes Ms Quaine referenced that commenced from 1 July, to collect more information about the impact of the programs. We will be auditing the outcomes to ensure that they are effective. But the MedsCheck is a structured program which is designed to address the poly-pharmacy issue that may be arising—where people have been on medicines for a long time that have not been reviewed and have had more medicines added to their regime to address some of those issues that you raised yesterday.

Senator LEYONHJELM: I think I am under the right item number with my question. I asked a question on notice after the last estimates which led to the advice that there are 1,476 doctors certified to prescribe Mifepristone or RU-486. My question is: of those doctors, some might consent to their names and practices being published to improve access to medical terminations. I am wondering what barriers there might be to publishing a list of such doctors and do you think it would be helpful to assist women who are seeking a medical termination?

Ms Shakespeare: I think the department would need to very carefully consider our obligations under I think it is section 135 of the National Health Act, where it is actually a criminal offence to reveal information that we collect for the purposes of administering the PBS basically in a way that is going to disclose individuals, whether it is doctors or patients. However, I suppose there would be nothing to stop those practitioners themselves advertising that they are available, have completed the training and can prescribe those medicines.

Senator LEYONHJELM: You have not quite answered my question. I did use the word 'consent'. If the doctors were to consent to having their names and practices published in order to improve access of women to medical terminations, the logical publisher of that information of those doctors who consented would be the department I would have thought. There would be no legal barrier and no legal impediment to that occurring if they consented. What would be any other barriers? In terms of privacy there would be no barrier.

Ms Shakespeare: I am not sure, Senator. I would need to seek advice on the operation of that provision in the National Health Act.

Senator LEYONHJELM: What I would like to know is, firstly, whether there are any other impediments to the department doing that and, secondly, whether the department acknowledges that that might actually result in increased options for more women?

Ms Shakespeare: I suppose the other factors we would need to consider are the cost to the community of the government supporting the publication of that information on government information sites and the costs of making sure that is kept up to date when there are so many practitioners who may change their circumstances. So we would probably need to look at other options for that information to be made public, including through direct advertising by the practitioners.

Senator LEYONHJELM: All right. Can you accept that question on notice and respond accordingly. You can certainly include that kind of consideration. Thank you.

Senator WATT: I just have some questions about the PBS. Starting in general terms, the budget measure 'Improving Access to Medicines—additional funding for new medicines and improved payment administration' says that the government will set aside a provision of $1 billion over the forward estimates for the PBS. What is the year-by-year profile of that provision?

Ms Shakespeare: There is no year-by-year profile that I am aware of. The provision is $1 billion. That funding will be made available to support the listing of medicines as and when they are recommended by the independent Pharmaceutical Benefits Advisory Committee.

Senator WATT: So the department has done no work to work out how much might be needed from one year to the next out of that $1 billion?

Ms Shakespeare: PBS listings are driven by applications to the Pharmaceutical Benefits Advisory Committee. It is incredibly hard for us to forecast when particular medicines will be

brought forward. It depends largely on factors that are in control of the pharmaceutical industry and other factors like when registration is achieved.

Senator WATT: Can you point me to anywhere in the financial impact table for this measure where that provision is reflected?

Ms Shakespeare: The $1 billion is referenced in Budget Paper No. 1 as a provision. It does not appear in the forward estimates for the Pharmaceutical Benefits Scheme in the Health portfolio budget statements. That is because it will be funding medicines that will be brought forward in the future and we do not know when they are going to list. So it is not built into the forecast at this time. The costs of those listings will be included in the PBS as new medicines are listed.

Senator WATT: Can you direct me to the relevant page of budget papers where I can find that?

Ms Beauchamp: It is page 621, Senator.

Ms Platona: It is also in Budget Paper No. 2, page 112.

Senator WATT: So there are two different references, are there?

Ms Platona: The figure of $1 billion is referenced in Budget Paper No. 2.

Senator WATT: What page am I looking at in Budget Paper No. 2?

Ms Platona: Page 112.

Ms La Rance: There is a third place you may wish to look—

Senator WATT: Hang on—I am just doing them one at a time. So Budget Paper No. 1 makes mention of a provision of $1 billion. That is in that first paragraph below the table. Is that right?

Ms Beauchamp: That is correct.

Ms La Rance: And the table reflects the $1 billion.

Senator WATT: The table does? Can you show me that?

Ms La Rance: Sorry, the chart.

Ms Platona: On page 621

Senator WATT: Of—

Ms Platona: Budget Paper No. 1, page 621.

Ms La Rance: It is statement 6, page 21.

Senator WATT: I can see the chart here.

Ms Shakespeare: There is a note underneath (a)—'expenses include $1 billion that the government has provisioned for new medicines listings'.

Senator WATT: So that dotted line that represents PBS expenses includes that $1 billion?

Ms Platona: From the period 2021-22.

Senator WATT: From then onwards?

Ms Beauchamp: Over that period of the forward estimates.

Senator WATT: Yes, over the forward estimates.

Ms Platona: Also in the chart.

Senator WATT: Before I ask the question, what was the third place?

Ms La Rance: The third place is in the Department of Health portfolio budget statements footnoting that the expenditure is the $1 billion. It is on page 93 of the Health PBS and then on page 95.

Senator WATT: Where is it on page 93?

Ms La Rance: Page 93 has the Medicare Guarantee Fund—the PBS payments are through a special account.

Senator WATT: So this $1 billion is built into the—

Ms La Rance: No, the $1 billion is not in there. The difference is that they are our forward estimates for the Department of Health. The $1 billion is factored in at a whole-of-government level. As Ms Shakespeare said, there has not yet been agreement as to which particular medicines they will be used for. When that happens, they will then be reflected in the agency forward estimates.

Senator WATT: Is that factored in in any table in any other department's budget papers if you say it has been factored in into whole-of-government? I cannot remember exactly how you put it.

Ms La Rance: It is at a whole-of-government level—the Commonwealth's whole-of-government financial statements. I would have to check which lines in the financial statements it does pull through to. As you can see, in Budget Paper No. 1, statement 6, the functional split of expenses, which then wraps up to a whole-of-government level, does include the $1 billion in there.

Senator WATT: Okay. Can you come back to me with where this $1 billion is shown up at a whole-of-government level if there is any—if it is the Department of Finance or any other department?

Ms La Rance: It is in the whole-of-government—it is probably a question that is best directed to the finance department, but it is in the whole-of-government financial statements.

Senator WATT: Just going back to this chart on page 6-21 of Budget Paper No. 1, you have pointed out that the dotted line there that says that PBS expenses include this $1 billion over the forward estimates. So, if it is represented there, surely there must have been some estimate on a year-by-year basis so that you know where to plot the line on the chart for the relevant year.

Ms Platona: In Budget Paper No. 2 on page 112, the $1 billion is described as a provisioning—that is, new money net available for future new listings, which are unspecified, coming out of the future PBAC meetings. What the measure also shows at the top of page 112 is that there is no diminution of investment—that the amount of revenue and the amount of expense is all netted out to no change in government investment.

Senator WATT: Is there a particular account within government that the money is held in until it is spent? You said it was factored in at a whole-of-government level.

Ms Shakespeare: It is a provision, Senator.

Senator WATT: So it is not being held in an account outside of your department, but equally it has not been allocated to your department at this point in time?

Ms Shakespeare: It will be as new medicines listings are made.

Senator WATT: If it is not showing up year by year and it is not showing up in any account or financial table, isn't this provision meaningless?

Ms Beauchamp: I think the officers have said that there has been a provision made in the budget statements. Obviously, it is the Treasurer's statement and these form part of the appropriation bills, so that $1 billion has been provided for over the forward estimates as indicated in Budget Paper No. 1.

Ms Platona: The next meeting of Pharmaceutical Benefits Advisory Committee is coming up in July. I have no doubt that the committee, amongst its 50 or so applications, will find products worthwhile to make a positive recommendation on.

Senator WATT: That may well be the case. I suppose I am just trying to see that there is some money somewhere that can be used rather than being just a bit of a promise and a couple of lines in a budget paper.

Ms Shakespeare: There is a provision. It is in the budget papers.

Ms Platona: And we will spend the money, Senator.

Senator McKenzie: That is not just a throwaway line there.

Senator WATT: It says that, but it is not in any—

Senator McKenzie: It is the federal government budget papers.

Senator WATT: We know how much to rely on your commitments. It says that, but it is not showing up in any table.

Ms Shakespeare: We have explained the reason for that though. We need to see the listings. The listings have not yet come forward.

Mr Wann: I would say that provisioning is a very normal part of government management of moneys. The provisioning is held by Finance. Really, any questions on provisioning and its treatment are to be directed to the Department of Finance.

CHAIR: Can I jump in. I accept that provisioning is a standard practice. Is one of the reasons that provisioning is important in this kind of area—

Mr Wann: In this context it is unique, but I am just talking a bit more generally. Provisioning is a standard practice.

CHAIR: Yes, but part of the reason it would be useful in this context is that I would assume PBS listings are very lumpy fiscally. In some years there might be none and in some years there might be a large number with a significant budget impact.

Mr Wann: That is exactly right. I guess the fact of the matter is that this money has specifically been set aside. In our PB statements there is a footnote that goes to—in the context of the Medicare Guarantees Fund there is a footnote that explicitly indicates that that provisioning has been set aside. So it is not—but I just have to stress that provisioning is a matter for Finance. We do not manage those moneys. They do. Really, we are not in a position to say too much more than that except that we draw on it as new listings are made.

Mr Henderson: If you refer to Budget Paper No. 1, page 6-10 in table 3.1, in that table there is a line 'Pharmaceutical benefits services and supply'. If you then refer to page 6-20 it

states that the pharmaceutical benefits services sub-function also includes an increase of $1 billion, reflecting the government's decision to provision this for new medicines listings.

Senator WATT: Okay. So does that mean that within that line item—pharmaceutical benefits services and supply—the figures that are shown there include the $1 billion?

Mr Henderson: Yes, they include that $1 billion.

Senator WATT: So, again, there must have been some attempt at breaking it down on a year-by-year basis.

Mr Henderson: That would have to be a question towards the Department of Finance.

Senator WATT: But they are your budget papers. You must know—

Ms Shakespeare: Senator, these are not our budget papers.

Senator WATT: I am sorry—

Ms Beauchamp: These are not our budget papers. These are the Treasury's.

Senator WATT: I thought it was in Health. Okay.

Mr Henderson: I almost got a promotion.

Senator WATT: That is helpful. Thank you.

CHAIR: Just to be clear, this is a demand-driven program. So the amount of—

Ms Shakespeare: It is. It has a special appropriation.

Senator WATT: Are you aware of a statement by the Medicines Partnership of Australia on 9 May in response to the budget? I have one copy of that if you have not seen it.

Ms Beauchamp: I would like to get a copy of it.

Senator WATT: It sounded like someone had seen it though. What you will see there—and just by way of background, the Medicines Partnership of Australia is made up of six peak bodies, including Medicines Australia, the Generic and Biosimilar Medicines Association and the Pharmacy Guild. What they have said in their statement is that, even accounting for the $1 billion provision that we have been discussing and some new listings—and I will come to that—the Medicines Partnership of Australia says that PBS expenditure is continuing to decline in real terms. Is that correct?

Ms Shakespeare: Expenditure on the PBS, taking into account the $1 billion provision, will increase. I think Ms La Rance has the figures.

Ms La Rance: I direct you again to that table, which does demonstrate—

Senator WATT: Which table, I am sorry?

Ms La Rance: It is statement six, Budget Paper No. 1, page 21. There are three lines in that table. The top one is the gross expenditure on the PBS, so what the government currently pays out or is estimated to pay out. The line down the bottom shows the revenue that comes back in the form of rebates. In terms of the actual cost to government of the Pharmaceutical Benefits Scheme, it is really that line in the middle. I think that the point that Ms Platona made was that under the proposed changes to payments administration there is no net change in terms of a reduction in payments. It is just changing the way that it is reflected. The darker line in the middle—the thicker line—shows that the actual payments that are being made on

the PBS or are estimated to be made over the forward estimates is tracking up slightly when you include the $1 billion of new listings.

Senator WATT: Looking at this chart, the line 'PBS expenses' actually does fall from 2017-18. But, even if we take what you are saying—that the line to look at is overall PBS investment—I can see there that there seems to be a marginal increase in nominal terms, but what the Medicines Partnership is talking about is expenditure growth in real terms. What they said in their statement was that PBS expenditure on pharmaceutical benefits and services is estimated to decrease by 7.3 per cent in real terms over the period 2018-19 to 2021-22. Are they wrong?

Ms Shakespeare: I am not sure how they are calculating real terms either. So it would be—

Senator WATT: As you know, even if it is the case, as you say, that the number of dollars is increasing in nominal terms year on year—it is going from $10 to $11 to $12—that may not mean that it is keeping up with inflation generally or health price indexes—

Ms Shakespeare: or the cost of producing medicines.

Senator WATT: Yes.

Ms Shakespeare: I think we have quite a lot of data about the costs of medicines actually reducing over time. We have seen particularly through measures around tracking the prices of medicines that have multiple brands and price disclosure that medicines prices have been reducing.

Ms Platona: To that statement that these organisations made, the number of prescriptions is continuing to grow on the PBS. So people are still accessing the PBS and the number of scripts is going up. As to the comment about some medicines and some funding from medicines, it has actually been $3.5 billion over the forward estimates since 2017-18 budget. It is not a small number. Thirdly, there are significant changes in the structures of the PBS through ongoing savings delivered through iterations of the price disclosure policy that has now been in operation since 2007 and, more recently, the statutory price reductions in the F1 formula.

Ms Shakespeare: That were agreed with industry.

Ms Platona: Yes.

Ms Beauchamp: Can I also confirm, too, what the statement also sets out. I particularly want to refer to Budget Paper No. 1 again. It says that there will be no reduction in the government's overall investment in the PBS as a result of the changes that we are looking at in terms of administrative arrangements. But, again, this press release that you have just provided—the budget makes a commitment to invest $2.4 billion in new medicine listings over the forward estimates, which is $1.4 billion announced for new listings and $1 billion for the provision that we have spoken about. So the MPA welcomes this announcement of new listings and the provision as well.

Senator McKenzie: I have a press release from the MPA dated 10 May which says in the first sentence that they 'warmly welcome the federal government's additional investment in the PBS in this week's budget'. Then it goes on to exactly outline the investment as per the

department. I would like to table the 10 May press release just so that we all have a fulsome picture of the MPA's—

Senator WATT: I am glad you raised that, because I was actually going to ask about that. I noticed that one day after the Medicines Partnership of Australia, which includes all of the major pharmaceutical bodies in Australia, issued a statement essentially condemning the budget and saying that PBS expenditure is going to decline in real terms, mysteriously the following day—

Senator McKenzie: I do not think you are typifying—on page 2 of their 9 May release they do say that the MPA welcomes—the government will continue consultations et cetera. So it is not—I think if you typify it as highly critical then I think that is a false characterisation.

Senator WATT: In their first statement on 9 May they criticised the government on the basis that expenditure on pharmaceutical benefits was going to decrease in real terms over the forward estimates and yet the very next day they issued a statement that does not retract their earlier statement but it certainly strikes a more positive tone towards the budget.

Senator McKenzie: It probably gives a more holistic picture of their view.

Senator WATT: Minister, do you know anything about the background of why they issued a second statement the following day?

Senator McKenzie: No, but I am assuming they wanted to make sure the public and the press knew the entirety of their response.

Senator WATT: Ms Beauchamp, did anyone in the department have any discussions or exchanges with the minister or his office regarding the first statement from Medical Partnerships?

Ms Beauchamp: I am not aware of any of those discussions.

Senator WATT: Are any of your officials?

Ms Shakespeare: No.

Senator WATT: You had no discussions with the minister or his office about the prospect of Medicines Partnership issuing a second statement the next day?

Ms Beauchamp: No—indeed, that would be quite unusual.

Senator WATT: Did anyone in the department have discussions or exchanges with the Medicines Partnership or any of its member organisations about the first statement that it issued on 9 May?

Ms Beauchamp: Again, not that I am aware.

Senator WATT: Could you take that on notice, because obviously there is a range of people behind you and you might not be aware that other people in the department may have had discussions. But none of the people at the table are aware?

Ms Beauchamp: No.

Ms Shakespeare: No.

Senator WATT: Equally, no-one in the department, to your knowledge, had discussions with the Medicines Partnership about putting out a second statement?

Ms Beauchamp: No—as I said, that would be unusual behaviour for public servants to engage in.

Senator WATT: Exactly—I agree. Is the department aware of any discussions or exchanges that occurred between the minister or office and the Medicines Partnership or any of its member bodies on the first statement or the second statement?

Ms Beauchamp: Again, I am not aware.

Senator WATT: No-one at the table is aware of any discussions between the minister's office and—and you are not, Minister?

Senator McKenzie: No.

Senator WATT: Is anyone in the department aware of reports of discussions between the minister or his office and the Medicines Partnership—for instance on 11 May the trade journal PharmaDispatch reported—

Senator McKenzie: Is this a regular publication? Did you say the Farmer Dispatch?

Senator WATT: The PharmaDispatch. You would be aware of that publication?

Ms Shakespeare: Yes.

Senator McKenzie: I thought it was agriculture.

Senator WATT: Did you see the article on 11 May where it reported that 'what remains unclear is the extent to which the office of health minister Greg Hunt pressured the Medicines Partnership of Australia to issue the second statement. Mr Hunt and his office are understood to be annoyed that the sector has not openly eulogised the budget'. Are you aware of that report, to begin with?

Ms Beauchamp: We are aware of the article. Any of those questions and that speculation would have to be directed to the minister's office.

Senator WATT: As you know, he is not here and his office is not here.

CHAIR: But Minister McKenzie is here.

Senator WATT: Yes, I will come to the minister. Just confirming what you said before, you have had no discussions with the minister or his office about his reaction to either of those statements from the Medicines Partnership?

Ms Beauchamp: No. Personally, I have not, but, as I have said, we have taken it on notice.

Senator WATT: Minister, can you shed any light on this? Are you aware of whether the minister or his office put pressure on Medicines Partnership to issue a second statement?

Senator McKenzie: No, I am unaware, Senator Watt, and until now I did not realise PharmaDispatch—I misunderstood it, being a good National Party senator.

Senator WATT: I would hope National Party people would have an interest in pharmaceuticals as well.

Senator McKenzie: Obviously, and community pharmacies in particular.

Senator WATT: Sure. It does seem strange that on one day this body issues a statement criticising what they say is a decline in real expenditure and then the very next day they issue

a statement that is a much more positive statement about the budget. It would appear that something has happened in between those statements.

Ms Beauchamp: We will take that as a comment. Obviously, we cannot make any comments on that.

CHAIR: You would need to ask these questions of the groups that are involved in the MPA.

Senator WATT: We may will do that. But, again, they cannot be called before estimates unless we have a Senate inquiry, I suppose.

CHAIR: Always an option.

Senator WATT: After the statements were made, the minister reportedly called a meeting with medicine companies in Melbourne on Wednesday 16 May a weeks after that first statement. Are you aware of that meeting having occurred?

Ms Shakespeare: Yes.

Senator WATT: Did any of you attend that meeting?

Ms Shakespeare: No.

Senator WATT: There were no departmental representatives present?

Ms Shakespeare: The department was not involved.

Senator WATT: Was the department aware of the meeting before it occurred?

Ms Beauchamp: It should be understood that the minister meets with many stakeholders very often without departmental representatives.

Senator WATT: Okay. So you knew about the meeting before it occurred?

Ms Shakespeare: Yes.

Senator WATT: What were you told was the purpose of the meeting?

Ms Shakespeare: We were simply advised that the minister had organised a meeting in Melbourne with pharmacy stakeholders.

Senator WATT: No-one else was ever told what the point of that meeting was?

Ms Shakespeare: No. I think a briefing on pharmacy issues was requested from the department, which we duly provided.

Senator WATT: And, Ms Beauchamp, you do not know anything more about what the purpose of that meeting was?

Ms Beauchamp: No. As I said, the minister meets with many stakeholders on many occasions and we are sometimes not privy to the agendas. But I think in the course of doing business in the health portfolio it is important that we do maintain open and productive relationships with all key stakeholders.

Senator WATT: Sure. I will quote from a different PharmaDispatch article, which said that the reason for this meeting was that Mr Hunt and his personal staff are understood to have openly expressed frustration at an industry increasingly sceptical about the budget. Do you know if that is correct?

Ms Beauchamp: No, and I would not comment on an article from PharmaDispatch.

Senator WATT: I am not asking you to comment on the article. I am asking whether you are aware of Mr Hunt and his staff having openly expressed frustration at the industry at this meeting.

Ms Beauchamp: I am not aware.

Senator WATT: Has the minister or his office ever expressed their position to you about the statements made by Medicines Partnership or the industry generally in response to the budget?

Ms Shakespeare: No.

Ms Beauchamp: No, there have been no comments made to me about it.

Senator WATT: So, if they are openly expressing frustration, it is behind closed doors and among themselves, because it hasn't happened in front of you?

Ms Beauchamp: I think you are reporting from a journal article and the credibility of that—I do not know the credibility of that and the source of that advice.

Senator WATT: Given the second statement that was issued a day after the first statement and this meeting that occurred with the industry within a week of their first statement, have you any explanation as to why the minister and his office appear to be very sensitive about PBS spending?

Ms Beauchamp: I think, as I said earlier, the minister meets with many stakeholders on many occasions, covering a broad range of issues. As we have identified and is clear in the portfolio budget statements, the Pharmaceutical Benefits Scheme and associated expenditure form a very significant and large part of the portfolio's business.

Senator WATT: Turning to the budget measure on new and amended listings, it says there that the government will provide $1.4 billion over five years for new listings—and I should point out that Labor welcomes that. But, again, it looks as though that figure reflects published prices, not net prices after rebates. Is that correct?

Ms Shakespeare: Yes.

Senator WATT: So what is the net figure after rebates—so, the actual cost to government?

Ms Shakespeare: I'm not sure whether we have that or could provide it. We would need to take that on notice to look at it.

Senator WATT: But isn't that the important figure for anyone who is trying to understand the cost to government—the net cost after rebates come in?

Ms Shakespeare: Net in PBS terms is quite complex. We have revenue that is paid under special pricing arrangements, which is usually clearer and easier to forecast. There's also revenue associated with risk-share agreements, which may or may not be activated. So, we generally don't publish revenue associated with PBS expenditure until after the end of the financial year.

Senator WATT: Is there somewhere within the budget papers that shows the rebates that are received?

Ms Shakespeare: They're not for publication.

Senator WATT: Why is that?

Ms Shakespeare: We're very careful about making the net costs—so, the effective price of medicines—public. One of the key tenets we have within the PBS is making available new medicines at a cost-effective price. But often, for a new medicine, a company will be unwilling to publicly disclose that effective price, so we have confidential deeds that those prices hidden.

Senator WATT: I can understand that, at an individual level, it would be commercial-in-confidence for a particular manufacturer if their rebates were disclosed, but I'm just asking in a global sense.

Ms Shakespeare: In a global sense, though, we look at the revenue at the end of the year.

Senator WATT: Are you able to tell me what it was for the last year?

Ms Shakespeare: We have revenue figures available for 2016-17, which have now been published and the revenue figure for that year was $3.3 billion.

Senator WATT: The review figure?

Ms Shakespeare: Revenue.

Senator WATT: That's the rebates?

Ms Shakespeare: That's global revenue associated with PBS listings.

Senator WATT: $3.3 billion in 2016-17?

Ms Shakespeare: That's the last year for which we published revenue.

Senator WATT: What else is encompassed in these revenues, apart from rebates?

Ms Shakespeare: I'm not sure what you mean by 'rebates'. It's revenue that's paid to the Commonwealth under confidential deeds entered into under section 85E of the National Health Act.

Ms Platona: Senator, I know that you have asked the question on notice as well about the number of special pricing arrangements. There are two components. One is revenue arising from higher published prices than effective prices The other one is revenue arising from re-scheduling arrangements that perhaps are not also associated with higher published prices than effective, but it's part of the risk management of how a medicine is used on the PBS. If a medicine listed on the PBS exceeds its initial agreement about volume of use then that would be a risk-sharing arrangement.

Senator WATT: I have seen it reported that the net figure is around about $750 million. Does that sound about right?

Ms Platona: We'll have to take that on notice.

Senator WATT: Thank you. The government has committed to list all drugs recommended by the independent Pharmaceutical Benefits Advisory Committee. Has it committed to do that within a certain time-frame?

Ms Shakespeare: We have a performance target, I think, of 80 per cent listed. There is a commitment in the portfolio budget statements about the proportion of medicines that will be—maybe it's dealt with by the PBAC.

Senator WATT: I understand your annual report has a metric being the percentage of submissions for new medicines that are recommended for listing by PBAC that are listed on the PBS within six months of agreement of budget impact and price.

Ms Shakespeare: That sounds like the one.

Senator WATT: I take it that means that a PBAC recommendation, then post-PBAC recommendations negotiations between the government and the sponsor, should all occur within six months?

Ms Shakespeare: That's what we aim for, so there is a target number there. It's not always possible.

CHAIR: This is about price negotiations, is that correct?

Ms Shakespeare: There are a range of things that need to be settled after the PBAC has recommended that a medicine list. That can include price negotiations. The length of those often depends on the willingness of the sponsor to accept what has been recommended as a cost effective price by the PBAC. There can be other factors in terms of the sponsor's ability to supply in the Australian market. On occasion we have more complex listings where restrictions take quite some time to settle with the sponsor. We have some restrictions that go to dozens of pages in length. We also have more complex listings where we have a medicine that, rather than being a first-in-class, is joining a series of other medicines that are already listed for a particular indication, where there may be reshare agreements in place that need to be re-negotiated for the addition of a new medicine. It can be quite a complex, lengthy process.

CHAIR: Do we know the average time for the medicines listed, say, under this government? How many new medicines have been listed since 2013?

Ms Shakespeare: We do have that figure.

Ms Platona: As I said, the value of them as a gross figure is $3.5 billion since the last budget.

CHAIR: I was meaning more the numbers.

Ms Beauchamp: Since October 2013, 1,741.

CHAIR: 1,741 drugs have been listed?

Ms Beauchamp: Yes, averaging 31 new and amended listings per month. That is approximately 1 per day.

CHAIR: That's many more than I thought. For new drugs coming in, do we have an average length of time?

Ms Shakespeare: There would be an average we could calculate. The majority are listed within that target 6-month period, but there will be an odd one that takes a lot longer for particular reasons.

Senator WATT: Is the target 80 per cent, did you say?

Ms Platona: Correct.

Senator WATT: So 80 per cent of submissions for new medicines that are recommended by PBAC to be listed on the PBS within six months of agreement of budget impact and price. Between the fact it is 80 per cent and there's a 6-month period there is a bit of wriggle room there to allow for negotiations or delays for one reason or another. I notice that even with that target, the government only met that target of six months 85 per cent of the time in 2016-17,

and that was down from 92 per cent in 2015-16. Is there any reason for that fall in the number of listings made within that target time frame?

Ms Shakespeare: It would have been associated with the factors for the particular medicines listed in that year.

Senator WATT: It's not an issue of resourcing or any formal or informal decision of government to hold out listings?

Ms Shakespeare: We've continued to meet our targets.

Senator WATT: In that you've surpassed 80 per cent?

Ms Shakespeare: We have.

Senator WATT: Seven per cent over one year seems like a reasonable fall. Is there any reason beyond individual negotiations over drugs for that fall?

Ms Shakespeare: There are many factors associated with how quickly we can finalise a listing.

Senator WATT: Turning to some of the medicines or vaccines that have been listed in this budget, we've done some research on the delays post PBAC recommendations. I'm happy to be corrected on these, but can I just put a few to you. Ocrevus for multiple sclerosis was recommended in July 2017 and listed in February 2018, so that was a seven-month delay. Keytruda for Hodgkin's lymphoma was recommended in August 2017 and listed in May 2018, a 9-month delay.

Ms Beauchamp: Can I just clarify, they are not delays as such. These are subject to complex price negotiations and the like, and they take what it takes to negotiate an effective price.

Senator WATT: So we can't use the word 'delay' or 'cuts'?

Ms Beauchamp: I don't think 'delay' is appropriate in this sense.

Senator WATT: Adacel l was recommended for pregnant women to prevent whooping cough in March 2017 and will be listed in July 2018, which is a 16-month period.

Ms Shakespeare: There is a different funding process for the national immunisation program. That is different from the PBS. It is not covered by the PBS targets. The officers who will be able to talk to you about the national immunisation program I think appear in the outcome after us.

Senator WATT: To wrap up the examples—it might be the same point here—Boostrix was recommended for pregnant women to prevent whooping cough. It was recommended in July 2016 and will be listed in July 2018, two years later.

Ms Shakespeare: That is another national immunisation program item.

Senator WATT: With the lengthy periods we're talking about, and even the earlier ones—seven months and nine months—being more than the six-month target, with periods of time like that, do you really think the government is in a position to boast about listing all medicines recommended by the PBAC?

Ms Platona: May I refer you to what the criterion is on page 104 of the portfolio budget statement. The criterion says, 'percentage of submissions for new medicine that are recommended for listing by the PBAC that are listed on the PBS within six months of

agreement of budget impact and price.' That means that once a company has a positive PBAC recommendation and a price is successfully negotiated between the department and the company and the budget agreement is settled, then it is from that point on that the six months kicks in. So when you're saying it took these drugs—and I'm happy to go through individual ones in my own dulcet tone for every single one of them—the point is that that six, eight or nine months that you are quoting actually includes the price negotiation, the budget impact agreement and so on. The criterion really says that once all that hard work is done, it is then six months onwards. So for those drugs, I believe we have met the criteria.

Senator DEAN SMITH: Senator Watt says he is happy to be corrected. You're correcting him.

Ms Platona: I'm providing clarifications, with the senator's indulgence.

Senator WATT: Do you accept, though, that there is a point at which the amount of time taken for negotiations or reaching agreement or listing, that the amount of time taken is so long that effectively a delayed medicine is really a denied medicine—it's just being pushed out?

Ms Shakespeare: No. There are not delayed or denied medicines in terms of the government not wanting to take forward recommendations from the PBAC. The department works very hard in every case to effect a positive listing. Sometimes those negotiations are harder and longer than for other medicines, but in every case we work as hard as we can to get that medicine to the Australian community as quickly as possible.

CHAIR: Before we move off this issue, Minister, can you confirm it is the government's position that all drugs that are recommended are listed?

Senator McKenzie: Yes, that's been our practice and our commitment.

CHAIR: And for the department, can you compare that with the position of the previous government? Was that the policy of previous governments?

Ms Shakespeare: I am aware that there was a policy at one stage that medicines could not list until offsetting savings had been identified, but I wasn't involved in this program at that time.

Senator WATT: Could you take on notice which drugs did not meet the time target in each year since 2013-14?

Ms Beauchamp: I think we've already provided an answer to a question on notice, it might have been a couple of estimates ago, where we've gone through the history of some of those, but we'll update that.

Senator WATT: Thanks. I want to go back to the budget measure 'improving access to medicines—additional funding for new medicines and improved payment administration'. One part of that measure is that revenue rebates for some high-cost medicines will be reduced from 1 July 2018 with the agreement of the relevant medicine manufacturers. Can you explain that change?

Ms Shakespeare: There have been some discussions with multiple companies that have medicines which have higher public prices and are generating quite a lot of revenue rebates, to reduce the differential between their public and effective prices. Those changes that have been agreed will be implemented from 1 July. That will reduce the impact on pharmacists for

some of the medicines where we've identified, particularly through the pharmacy review, that the high public price that they need to pay to source those medicines into their pharmacies is discouraging them from stocking those medicines.

Senator WATT: How many medicines are involved?

Ms Shakespeare: We're still finalising that. There are at least two, possibly three.

Senator WATT: Two or three? Are you able to say which ones?

Ms Shakespeare: I would prefer not to. It's just that we are still finalising those agreements with individual companies, and it might be possible to identify their information—it's commercially sensitive information.

Senator WATT: Are you at least able to say which manufacturers?

Ms Shakespeare: Again, we would prefer not to while we're still finalising the negotiations. There will be a benefit to the public if these negotiations are finalised in terms of access to high-cost medicines.

Ms Platona: The changes, once they are agreed, will be visible from 1 July.

Senator WATT: The measure also includes that an improved payment administration trial for certain high-cost medicines with special pricing arrangements will commence from 1 July 2019. What does that mean?

Ms Shakespeare: We are working with the various sectoral groups—pharmacists, wholesalers, medicines companies—to implement a trial for a range of medicines from 1 July next year where we will make direct payments to the manufacturers for those medicines at the effective price, and then also at the point those medicines are dispensed pay the pharmacy remuneration direct to the pharmacists. So there will be two payment channels, dispensing remuneration to the pharmacist, who then remits that as appropriate to the wholesaler, but the majority of the medicine price will be paid at the effective level directly to the manufacturers at the point that the claim is made to DHS.

Senator WATT: Why is the government pursuing this change? What's the rationale?

Ms Shakespeare: As I mentioned earlier, the pharmacy review identified that there are quite a high proportion of pharmacists that are indicating they are unwilling to stock some medicines that we have on the PBS for distribution through community pharmacy. I think the figure was 22 per cent had indicated that they were unwilling to stock these medicines because of the high financial impact. We do now have medicines to treat fairly common infections that can cost upwards of $20,000 a box. When a pharmacy have to pay out that amount of money, it has an impact on their cash flow and an impact on their rent sometimes if their rent is linked to their turnover. So to address that issue and to make sure that we're continuing to achieve the objectives of the National Medicines Policy, where we have medicines available to the Australian community when they need them through Community Pharmacy, we're looking at different payment arrangements that will not have that impact on the cash flow and turnover of pharmacies.

Senator WATT: So it's a pretty important change from the government's perspective and the department's perspective?

Ms Shakespeare: Yes, it is. It's a significant change.

Senator WATT: Have any companies already agreed to participate in this trial?

Ms Shakespeare: Yes.

Senator WATT: How many?

Ms Shakespeare: I do not have the number off the top of my head, but it's several.

Senator WATT: Do any of your colleagues know?

Ms Platona: I'm sorry, I don't know the exact number.

Senator WATT: Can you give us some examples of companies that have agreed?

Ms Shakespeare: I'd prefer not to. Again, the agreement is part of confidential deeds that they've entered into with the Commonwealth.

Senator WATT: Why is which companies have already reached agreement so confidential? It doesn't sound like anything's under negotiation.

Ms Shakespeare: No, the negotiations are certainly still continuing. As new medicines come forward for listing with special pricing arrangements, because we now know that we are moving towards a trial of new arrangements, we are looking not to use the same approach to negotiating these deeds as we did in the past, where the term of the agreements varied but there would generally be up to five years worth of agreed revenue payments. So, if we're moving to a new arrangement, we need to negotiate new deeds in those clauses, and those deeds are confidential.

Senator WATT: So several companies have agreed to participate in the trial.

Ms Shakespeare: Yes.

Ms Platona: Senator, you have used the word 'agreed'. At the moment, we are still working through options on how this machinery is actually going to function. The aim here, put simply, is to remove the need for companies to return money to the Commonwealth, but there is an entire supply chain for this cash—and in 2016-17 it was $3 billion and it will be $5 billion going forward. That moves through the supply chain. It involves the manufacturers, the wholesalers, the pharmacists and the Department of Human Services, which identifies the PBS scripts versus other types of private scripts. There are the states and territories for the section 100 Highly Specialised Drugs Program and both private and public hospitals. There's an entire supply chain of machinery, and we are at the stage where we are working through the better option, if you like. So at the moment I would really say that it's premature to describe the discussions that we have had with individual companies as agreements, because, in fairness to them, there's nothing yet to agree to. We have indications from a number of companies that they might be interested and that they are interested, but it's not an agreement. For us, an agreement means a contract—and that we do not have in place with any company at the moment.

Senator WATT: Okay. Is Boehringer Ingelheim one of the companies that you're in negotiations with?

Ms Shakespeare: Not at present.

Senator WATT: But you said that there are several other companies that you are in negotiations with.

Ms Platona: We had indications from them that they would be interested.

Senator WATT: I'm not going to pin you down on a number, but several sounds like five to 10—that kind of range.

Ms Shakespeare: Multiple.

Senator WATT: As in more than one!

Ms Shakespeare: Yes.

Senator WATT: But not Boehringer Ingelheim?

Ms Shakespeare: I said that we're not currently in negotiations with them, and I would prefer, again, not to identify individual companies unless you feel that is absolutely necessary.

Senator WATT: I am kind of keen to know. Have you reached agreement with Boehringer Ingelheim? You said you're not in negotiations with them.

Ms Shakespeare: They have a deed in place at the moment.

Senator WATT: Are they the only company that there is a deed in place with?

Ms Shakespeare: No. We have been negotiating clauses to allow the operation of this trial into contracts or deeds with companies that have listed with special pricing arrangements since the start of this year.

Senator WATT: So there are multiple companies that you have a deed in place with, including this one, and there are other companies that you're in negotiation with—

Ms Shakespeare: For new deeds.

Senator WATT: but you don't yet have a deed in place with—is that correct?

Ms Shakespeare: Yes.

Senator WATT: Does the financial impacts table in this measure reflect this trial?

Ms La Rance: In which measure? Whereabouts are you?

Senator WATT: It is 'Improving Access to Medicines—additional funding for new medicines and improved payment administration'.

Ms Platona: On page 112 of *Budget Paper No. 2*?

Senator WATT: Yes.

Ms Platona: What you see there is the equal movement of revenue and expenses over the forward estimates.

Senator WATT: Page 112?

Ms Platona: Yes. The table reflects the movement going forward of revenue and expenses. That tells you that

they all net out to really no change in government investment. That is the reassuring part of that table—apart from the scary number it adds up to, which is $5.4 billion.

Senator WATT: I presume that for you to have arrived at some figures, there must have been some modelling undertaken or some assumptions about the number of companies that will participate?

Ms Shakespeare: Yes, to produce those figures and the expenditure-reducing and revenue-reducing over the forward estimates.

Senator WATT: Do you know how many companies it is assumed will participate?

Ms Shakespeare: I would have to check on notice what has been assumed there. That was part of the costing process.

Senator WATT: Sure. Unless anyone knows the answer to that? No. Okay, if you could take that on notice. I now want to dig into special pricing arrangements in more detail. What exactly are they?

Ms Shakespeare: Special pricing arrangements: as I said, section 85E of the National Health Act states that the minister may enter into deeds that make provision for 'reimbursing the Commonwealth in relation to the provision of pharmaceutical benefits in circumstances set out in the deed'. That is generally what we refer to as 'special pricing arrangements', set out in paragraph 85E(3)(a) of the National Health Act. We can also have deeds that cover re-share arrangements where there might be caps on patient numbers or expenditure to ensure that a listing meets the conditions of a PBAC recommendation—so that the PBAC has recommended that it would only be cost effective up to these patient levels. That's generally what we have in confidential deeds.

Senator WATT: These are arrangements that are reached between the department and a manufacturer to essentially allow for the supply of a particular drug at a lower price than would otherwise occur?

Ms Shakespeare: With the special pricing arrangements component of deeds, it is generally that a company would like to keep the cost-effective price at which it has been agreed by the PBAC that the medicine would be cost effective and clinically effective. The company is concerned that that price may be used in other countries as a referenced price, and not all countries have the same health technology assessment based processes for determining medicines funding. We enter into these confidential pricing arrangements where there will be a public price on the PBS that is published through the legislative instruments, but the effective price is actually in line with what the PBAC has recommended is a cost-effective price. That is what we actually pay. The difference is recovered at the moment through revenue payments.

Senator WATT: How many of these special pricing arrangements are in place at the moment?

Ms Platona: We have 162 deeds of agreement.

Senator WATT: Does each deed deal with a particular drug or a particular manufacturer?

Ms Platona: The deed is for the drug.

Senator WATT: So, one manufacturer might have multiple deeds?

Ms Platona: Correct—yes.

Senator WATT: Are you able to give us a list of the drugs that you have these special pricing arrangements for?

Ms Shakespeare: It would be apparent from the PBS list itself, because we indicate on the legislative instrument where there is a special pricing arrangement in place. So, yes, we could. We would have to take that on notice.

Senator WATT: That's fine. But it is public that these arrangements are in place?

Ms Shakespeare: It would indicate on the schedule that there is a special pricing arrangement in place.

Senator WATT: I think there is a set of criteria for these special pricing arrangements?

Ms Shakespeare: There is a set of criteria, and I can explain how the criteria have been developed. Generally, it's fairly clear that there is an interest to a pharmaceutical company in having a special pricing arrangement. That's what I described before. It keeps the price from being referenced in other countries where they may be able to negotiate a higher price. But we do look for a public benefit before agreeing to a special pricing arrangement. Sometimes that can be fairly clear. Where we have a new medicine, first in class, patients will not get access to it unless there is a special pricing arrangement in place, and that's covered in the criteria. So, in that circumstance, it's quite clear why we'd enter into a special pricing arrangement. It can be more complex if there are existing medicines on the PBS that are for the treatment of that condition, so we have developed a set of criteria to give an indication to industry of when a special pricing arrangement will be entered into.

Senator WATT: And when were those criteria introduced?

Ms Shakespeare: I understand that they date from 2009.

Senator WATT: And have they been changed since then?

Ms Shakespeare: There have been some changes. For instance, the Pharmaceutical Benefits Pricing Authority used to be referenced in the criteria. That committee ceased to exist, I think, in 2014, so in the current criteria that's been removed.

Senator WATT: So the last change was made in 2014?

Ms Shakespeare: I'm not totally sure, but that is one example of a change that's happened.

Senator WATT: And who evaluates a proposed special pricing arrangement and advises government on whether it meets the criteria?

Ms Shakespeare: The department will provide advice to the minister. Some of the criteria relate to clinical factors. For instance—

Senator WATT: Does the Pharmaceutical Benefits Advisory Committee also advise government on whether a drug meets these criteria?

Ms Shakespeare: The PBAC's advice is sought on whether or not some components of the criteria have been met. There is no requirement for the PBAC to have provided advice to the government on whether or not it enters into a deed under section 85E in the same way that the PBAC must have recommended a medicine as clinically effective and cost effective before the minister can list it. Those provisions are under section 85 and section 100, and the references are in section 100 of the National Health Act. So there's not a similar requirement for the PBAC to have advised the government on whether or not it should enter into a confidential deed under section 85E.

Senator WATT: So the PBAC advises on whether the criteria are met, and the department advises on whether a drug should be—

Ms Shakespeare: Not quite. The PBAC must first have recommended a medicine for listing as clinically effective and cost effective. We must have a proposal from a company to list the medicine according to those circumstances and with that cost-effective price. Whether or not a special pricing arrangement is then offered to the company is something that the department advises on. However, for some of the criteria, there is a need to assess clinical

factors associated with the medicine—does it have unique characteristics?—and we seek PBAC advice on those parts of the criteria before making a recommendation to government.

Senator WATT: And, generally speaking, does the minister follow the PBAC's advice?

Ms Shakespeare: On those parts of the criteria that relate to clinical factors, yes.

Senator WATT: So the PBAC does, as a matter of practice, advise the minister on whether the criteria are met, and the minister, in general terms, follows the PBAC's advice?

Ms Shakespeare: If I can provide an example, the first part of criterion 2 on the special pricing arrangement criteria says:

The PBAC advises that the medicine has unique characteristics compared to any available alternative therapies …

That is something where we would seek, and the minister would follow, the PBAC's advice. There are other parts of the criteria. For instance, criterion 3 states:

… there is significant financial benefit that would accrue to the Commonwealth should the arrangement be agreed …

That's not something that we need PBAC's advice on. We're able to advise the minister on those issues ourselves.

Senator WATT: And you mentioned that there are 162 special pricing arrangements in place at the moment?

Ms Platona: We have 162 deeds of agreement as of 7 May. But not all of them are for special pricing arrangements; as I said, some of them have a resharing arrangements component. So the deeds could be other reasons, not only for special pricing arrangements.

Senator WATT: Do you know how many are for special pricing arrangements?

Ms Shakespeare: Most of them would include a special pricing arrangement, but we would have to go and count.

Senator WATT: Probably over 100?

Ms Shakespeare: I would say that is probably a safe assumption. Most of them relate to medicines on F1 and would have special pricing arrangements—effective and public prices.

Senator WATT: How many of the more than 100 special pricing arrangements that you have in place at the moment have been granted without PBAC advice?

Ms Shakespeare: I would not know whether we have sought specific advice on particular parts of the criteria from the PBAC.

Senator WATT: Are you aware of any special pricing arrangements that have been granted without PBAC advice?

Ms Shakespeare: Usually what may appear in a public summary document is that the sponsor has applied for a special pricing arrangement and the PBAC would have the opportunity, at the time it considers the listing, to say that it didn't support that. There are probably very few cases where the PBAC is asked specifically to look at the question of whether a special pricing arrangement should be available.

Senator WATT: Sure, but are there any where special pricing arrangements have been entered into without PBAC advice about whether the criteria have been met? You said that that is what their role is.

Ms Shakespeare: Not that I am aware of.

Ms Platona: In the usual course of applications to the PBAC the company makes it clear and discloses to the PBAC whether it is seeking a special price. The PBAC will need that information to be able to calibrate its financial assessment of an application. If the PBAC gives a positive recommendation to the product, then the department already knows that, in most cases, an application for a special pricing arrangement was sought by the applicant. The PBAC has no legislative powers with respect to special pricing arrangements.

Senator WATT: I think I understand now. Their role is about the criteria, not the granting of the arrangement itself.

Ms Shakespeare: Some elements of the criteria that require us to assess whether a medicine has unique properties—that is not something the department can advise on.

Senator WATT: Exactly, so that is what you rely on the PBAC to do?

Ms Shakespeare: Again, it is not that every criteria needs to have been—

Senator WATT: I understand that.

Ms Shakespeare: It is about what we assess in looking at whether a deed should be recommended to the minister.

Senator WATT: Again, what I think you just said before is that there are probably over 100 special pricing arrangements in place. You are not aware of any that have been granted without PBAC advice about the criteria?

Ms Shakespeare: Not that I am aware of.

Senator WATT: Are you aware of any that have been granted, or entered into, contrary to PBAC advice?

Ms Shakespeare: We have a medicine that was listed recently where the PBAC had considered whether part (a) of criterion (ii) had been met. The PBAC had been asked to advise whether the medicine has unique characteristics compared to any available alternative therapies and their answer to that question was no.

Senator WATT: What was the name of that drug?

Ms Shakespeare: Afatinib. However, there is a second part to that criterion. If you want me to go into the history of Afatinib—there is quite a lot of this publicly available—

Senator WATT: What sort of drug is that?

Ms Shakespeare: It treats advanced or metastatic non-small cell lung cancer.

Ms Platona: Its brand name is Geotrif.

Senator WATT: So the PBAC was asked to advise—

Ms Shakespeare: I will talk about the history to the listing of this one. It was first recommended by the PBAC following an application to its July 2013 meeting.

Senator WATT: So the application was made in July 2013?

Ms Shakespeare: To the PBAC.

Senator WATT: And when was it recommended for listing on the PBS?

Ms Shakespeare: It wasn't recommended immediately after that meeting. There was a further pricing negotiation. Following the successful conclusion of that pricing negotiation,

the PBAC recommended out of session that it be listed as clinically effective to treat that indication at a cost-effective price which the sponsor had indicated it was willing to accept. That would have been in the last few months of 2013 because we know that a special price agreement for that medicine was considered and advised by the Pharmaceutical Benefits Pricing Authority in, I think, December 2013.

Senator WATT: So it was recommended for listing on the PBS on December 2013?

Ms Shakespeare: It was recommended somewhere between July and December 2013 but I don't know exactly when it was reached out of session.

Senator WATT: And you say this drug has been listed on the PBS under a special pricing arrangement?

Ms Shakespeare: Yes, I think it was from 1 May this year.

Senator WATT: Quite recently. Back at the time when it was first recommended by the PBAC for listing on the PBS, what was the PBAC's advice on the eligibility of this drug for a special pricing arrangement at that point in time?

Ms Shakespeare: At that point in time the out-of-session recommendation by the PBAC was for an authority required listing of Afatinib—to treat locally advanced or metastatic non-squamous or other specific non-small lung cancer in patients with evidence of activating mutation of the EGFR gene in tumours—and to cost minimise to another medicine, Erlotinib.

Senator WATT: So back in 2013 the PBAC's advice was essentially that it was eligible for a special pricing arrangement?

Ms Shakespeare: It was recommended in comparison to another medicine which had a special pricing arrangement.

Senator WATT: Did that advice in relation to Geotrif, or Afatinib, subsequently change?

Ms Shakespeare: At some point between the recommendation of the special pricing arrangement by the Pharmaceutical Benefits Pricing Authority and the listing of that medicine, which did not proceed—the point at which the medicines company expected that that medicine would list—the sponsor of one of two other medicines that were considered by the PBAC to be comparators withdrew their special pricing arrangement and as of 1 April 2014 the comparator medicines had their public prices listed on the PBS. At some point after that, the department advised the sponsor of Afatinib that it was not eligible to list on the PBS with a special pricing arrangement.

Senator WATT: So in 2013 the PBAC essentially recommends that it be listed on the PBS and is eligible for a special pricing arrangement. But in 2014, for the reasons you have given, the advice changed and the PBAC in 2014 essentially recommended against a special pricing arrangement?

Ms Shakespeare: No. The department advised the company that it was no longer eligible for a special pricing arrangement. And then, in, I think, July 2015—

Senator WATT: Hang on. So the department advised against a special pricing arrangement in 2014?

Ms Shakespeare: The department, at that point, advised the company that it was not eligible to list.

Senator WATT: And what was the PBAC's advice in that process?

Ms Shakespeare: The PBAC had not given advice at that point.

Senator WATT: Its advice was not renewed after 2013 at that point?

Ms Shakespeare: Later, in July 2015, the company applied to the PBAC to seek the PBAC's advice that the medicine has unique characteristics compared to an alternative available therapy—the other two medicines. That is part (a) of the second criterion. I have copies of the criterion here.

Senator WATT: I have it here.

Ms Shakespeare: The PBAC provided advice on that question to say that it did not have unique characteristics compared to the other two listed medicines.

Senator WATT: So in 2015 the PBAC said it didn't have unique characteristics and essentially reconfirmed that it was—

Ms Shakespeare: No, it was different advice this time.

Senator WATT: But the PBAC in 2015 essentially said that the drug didn't pass the criteria for a special pricing arrangement?

Ms Shakespeare: It didn't pass criterion 2(a).

Senator WATT: Did the government follow the PBAC's advice at that time?

Ms Shakespeare: I am not sure whether there was a specific request to the department to provide advice to the minister to exercise the discretion to list with a deed following that PBAC decision.

Senator WATT: So the company attempted to enter into a special pricing arrangement in 2015. The PBAC said it didn't meet the criteria and there was no special pricing arrangement entered?

Ms Shakespeare: I am not sure whether the company asked for a special pricing arrangement to the department. I know that they made a PBAC application—

Senator WATT: Sorry, that's what I mean. In 2015, they made a PBAC application—

Ms Shakespeare: For advice on part (a) of that second criterion.

Senator WATT: and the PBAC said no—

Ms Shakespeare: The PBAC said they were not satisfied, based on the evidence, that that medicine had unique characteristics compared to available alternative therapies.

Senator WATT: After 2015, did the PBAC provide any further advice on Geotrif's eligibility for a special pricing arrangement?

Ms Shakespeare: I think there was another application to the PBAC to seek its recommendation to list in a smaller subpopulation. In fact, I might be getting my dates mixed up. It may have been July 2014 that they sought information on part ii(a) of the special pricing arrangement criterion. It may have been July 2015 when they sought to have the PBAC recommend a listing for a subset of the EGFR mutations patient population. Again, the PBAC recommended then that the data didn't indicate that they had superior clinical outcomes for that subpopulation of patients with that mutation.

Senator WATT: And this was after 2015?

Ms Shakespeare: That was July 2015.

Senator WATT: And nothing since then—up until recently?

Ms Shakespeare: In early October 2017, which is the first time I personally became aware of this listing history, the company applied to the department seeking for us to recommend to the minister to list this medicine with a deed of agreement and a special pricing arrangement.

Senator WATT: October 2017?

Ms Shakespeare: That's right—early October.

Senator WATT: Do you know the date?

Ms Shakespeare: I'm pretty sure it was 3 October. That would have been the earliest.

Senator WATT: Is there any reason you remember that date so clearly?

Ms Shakespeare: That's because we have been responding to requests for information about this listing.

Senator WATT: So around 3 October the company applied for what exactly?

Ms Shakespeare: That the department recommend to the minister that this medicine list in accordance with the earlier PBAC recommendation with a deed of agreement containing a special pricing arrangement.

Senator WATT: So they wanted to rely on the earlier PBAC advice?

Ms Shakespeare: I am not really willing to go into the specifics of the negotiations and what the company raised with us. Given the publicly available history to the listing of this medicine, the published criteria, I can give you an indication of why we reached a different conclusion here.

Senator WATT: We will come to that.

Senator SINGH: Is that criterion publicly available.

Ms Shakespeare: Yes. I have a copy here if you would like it.

Senator WATT: So in 2013 the PBAC advised that it met the criterion but a special pricing arrangement was not entered into at that point in time?

Ms Shakespeare: That was on the advice of the department to the company, not the advice of the PBAC.

Senator WATT: So the department advised against a special pricing arrangement in 2013 and then in 2014 the department again advised against a special pricing arrangement?

Ms Shakespeare: No, the company's applied to the PBAC, claiming that it had unique characteristics compared to available alternative therapies. The PBAC advised on that question that it did not.

Senator WATT: So in 2014, the PBAC advised that it didn't meet the criteria?

Ms Shakespeare: It didn't meet criterion ii(a).

Senator WATT: Could you just read out criterion ii(b)?

Ms Shakespeare: The full criteria is this:

ii. the PBAC accepts that the medicine has unique characteristics compared to any available alternative therapies OR the medicine is recommended for listing in comparison with a medicine which has a similar arrangement;

Senator WATT: Yes. That's the version I've got, too.

Ms Shakespeare: In this case, the PBAC recommended that the medicine be listed in comparison with the medicine which had a similar arrangement.

Senator WATT: So in 2014 the PBAC advised that the drug didn't meet the criteria for the reasons you've just given, and consequently—

Ms Shakespeare: The PBAC advised in 2014 that the medicine did not have unique characteristics compared to available alternative therapies.

Senator WATT: And on that basis there was no special pricing arrangement reached?

Ms Shakespeare: I'm not sure whether or not the company actually sought for the department to make a decision one way or the other in 2014.

Senator WATT: Then in 2015?

Ms Shakespeare: The company applied for, I suppose, a different listing for a different patient population.

Senator WATT: But the PBAC advised—

Ms Shakespeare: Reinforced its earlier recommendation.

Senator WATT: It didn't meet the criteria?

Ms Shakespeare: It didn't meet that first part of the criteria.

Senator WATT: There was no listing? The company didn't get what it wanted, effectively?

Ms Shakespeare: Again, I don't know whether or not the company applied to the department after that PBAC decision, seeking for a review of the decision not to enter into a special pricing arrangement.

Senator WATT: Then the next thing you're aware of is 3 October 2017, when the company began the process to seek a special pricing arrangement?

Ms Shakespeare: Yes. At that point the department carefully considered the case put forward by the company—we consider all of these applications on a case-by-case basis—and eventually recommended to the minister that this medicine be listed with a special pricing arrangement.

Senator WATT: Was PBAC advice sought prior to that recommendation?

Ms Shakespeare: No. The PBAC had already advised on particular components of the criteria before.

Senator WATT: Back in previous years?

Ms Shakespeare: Yes. This medicine was not listed with a special pricing arrangement because it had unique characteristics compared to available alternative therapies. That was not why the department recommended it.

Senator WATT: But the most recent advice from the PBAC, when this new application was received, was back in 2015 when the PBAC advised that it did not meet this criterion?

Ms Shakespeare: No. The PBAC had been asked to consider whether this medicine was superior, clinically, in treating a subpopulation—

Senator WATT: And it said no.

Ms Shakespeare: of the indication, which was eventually listed on 1 May.

Senator WATT: But it said no at the time?

Ms Shakespeare: The PBAC said the data did not support the claim of clinical superiority. That's a separate question.

Senator WATT: Sure. When this most recent application was made, the department didn't seek advice from the PBAC about whether it met the criteria?

Ms Shakespeare: We knew from earlier PBAC decisions and public summary documents that the medicine treats a significant medical condition—criterion i—and that they'd advised that it be listed as clinically effective and cost effective. We knew that the PBAC did not believe that the medicine had unique characteristics compared to available alternative therapies. However, that's not the entirety of the criterion ii. That criterion goes on to say:

… OR the medicine is recommended for listing in comparison with a medicine which has a similar arrangement;

At the time that medicine was recommended, that part of the criteria was met.

Senator WATT: Why did the department go from accepting the PBAC's advice earlier in relation to the first part—

Ms Shakespeare: We've always accepted the PBAC's advice in relation to that first part of the criterion.

Senator WATT: Why did you then move to rely on the second part of criterion ii to recommend the agreement?

Ms Shakespeare: I can't actually say what was considered back in 2014, because I wasn't involved then, but, when we were asked to review whether or not this medicine should be listed with a special pricing arrangement and we looked at the criterion, I think it was quite open to find that the medicine met that second part of the criterion, because when it was recommended for listing, it was recommended for listing in comparison with the medicine that had a similar arrangement.

Senator SINGH: What was that similar medicine?

Ms Shakespeare: Erlotinib had the same special pricing arrangement when the PBAC considered and recommended this medicine for listing.

Senator SINGH: Erlotinib?

Ms Shakespeare: Erlotinib.

Senator WATT: One of the reasons I suppose I'm a little bit confused is that earlier on you were saying that, of the 100 or more special pricing arrangements that are in place, you weren't aware of any that had been entered into without PBAC advice or contrary to PBAC advice, and what seems to have happened here is that PBAC advice was obtained a couple of years ago—

Ms Shakespeare: On one part of the criterion.

Senator WATT: on one part—and it essentially said that this drug didn't meet that part of that criterion, but then the department has recommended the listing on the other part of the criterion with no advice from the PBAC.

CHAIR: I think the witness really has answered that question.

Ms Shakespeare: The PBAC recommended listing this medicine, in comparison with the medicine that had a similar arrangement. It's fairly clear from the PBAC documents.

Senator WATT: So you believe that there is PBAC advice to support the listing on the basis of the second limb of criterion 2?

Ms Shakespeare: Yes, it dates from 2013, when the PBAC recommended this medicine. There is clearly some ambiguity here in the criterion about what happens when another medicine's company, which has an existing listing, withdraws its special pricing arrangement. Do we need that medicine to have a similar arrangement after the point of recommendation from the PBAC? Should it continue up until the point of listing? Should it continue beyond the point of listing? I think these are matters that we're going to have to work through with Medicines Australia to come up with clearer criteria around special pricing arrangements.

Senator SINGH: You said that the alternative, similar medicine was called erlotinib.

Ms Shakespeare: Yes. So the PBAC in its consideration of this medicine actually thought there were three drugs that were quite similar in terms of their clinical outcomes. The other two were erlotinib, which was the one that was formally recommended as cost minimised, and gefitinib.

Senator SINGH: When was that medicine listed—erlotinib?

Ms Shakespeare: I'm not sure exactly when erlotinib was listed. It was already on the PBS, though, at the time we're talking about in 2013.

Senator WATT: Did you or anyone else from the department have any discussions with the minister or his office about the listing of this drug and the company's request that a special pricing arrangement be entered into?

Ms Shakespeare: Yes, we would have discussed this with the minister's adviser before making recommendations.

Senator WATT: Before making recommendations?

Ms Shakespeare: Before formally putting this one up for listing with a special pricing arrangement.

Senator WATT: Did the minister's adviser, or the minister, give any indication about their view of whether it should be listed or not?

Ms Shakespeare: The minister was not directly involved in this.

Senator WATT: Yes.

Ms Shakespeare: I didn't discuss this one directly with the minister, but, yes, the adviser was comfortable with the advice we were providing.

Senator WATT: That's slightly different to what I asked. Did the minister's adviser give any indication of their view on whether this drug should be listed?

Ms Shakespeare: These are fairly complex listing arrangements, and I think they generally rely on the advice from the department.

Ms Beauchamp: I think the bottom line is Ms Shakespeare is saying that, in terms of our advice, the drug met the criteria, and I don't think it's up to the ministerial adviser to influence departmental advice.

Senator WATT: And that didn't occur here?

Ms Shakespeare: No.

Senator WATT: But you said that they were comfortable with the advice that you were intending to make?

Ms Shakespeare: Yes.

Senator WATT: So you had discussions with the minister's adviser prior to making formal recommendations?

Ms Shakespeare: Just to let them know what was coming.

Senator WATT: Okay. And in those—

Ms Shakespeare: We often have discussions about what's coming up in the next list.

Senator WATT: Sure.

Ms Shakespeare: We make them every month.

Senator WATT: Sure. In those discussions, you must have given some indication that you were heading towards a recommendation, and the minister's adviser was comfortable with that?

Ms Shakespeare: Yes.

Senator WATT: Right. But they didn't express a view themselves one way or another?

Ms Shakespeare: Not that I'm aware.

Senator WATT: You're probably aware that there have been some reports that the government granted a special pricing arrangement for this drug, Giotrif, in order to secure the support of its manufacturer for the improved payments administration trial we discussed earlier. You said that Boehringer Ingelheim, the manufacturer of this drug, is one of the companies that you've entered into a deed with.

Ms Shakespeare: We have now entered into a deed with that sponsor.

Senator WATT: So they are a participant in this trial.

Ms Shakespeare: We have a clause in the deed pertaining to the trial.

Senator WATT: Did the minister's adviser ever discuss Boehringer Ingelheim's support for the trial or desire to participate in the trial in the context of this decision about granting a special pricing arrangement?

Ms Shakespeare: No, the medicine, as far as we could tell, could make a very good case that it met the listing criteria. For all medicine companies with special pricing arrangements that we have entered into since 1 January this year, we have negotiated with the company to try to secure agreement to participate in the new payment arrangements.

Senator WATT: In any of the various discussions you had with the minister's adviser, prior to formal advice that this drug be listed for a special pricing arrangement, did Boehringer Ingelheim's support for the payment administration trial come up?

Ms Shakespeare: Not that I can recall. We would have been having discussions with the office about how we were proceeding with companies. We were having multiple discussions with multiple companies about participating in the trial. So we would have had discussions with them about which companies had agreed to support and which companies were less enthusiastic about participating.

Senator WATT: But there was never a discussion that you were a part of with the minister's adviser in which both issues came up—the company's support for the trial and its request for a listing for a special pricing arrangement?

Ms Shakespeare: Well, they may have come up in a conversation about a particular medicine listing.

Ms Beauchamp: But it would not have influenced the department's advice on a special pricing arrangement.

Senator WATT: In broad terms, who was involved in discussions about Giotrif being listed under a special pricing arrangement? Obviously you, Ms Shakespeare, and other officers—

Ms Shakespeare: And members of my team, the pricing team.

Senator WATT: Not the minister?

Ms Shakespeare: No

Senator WATT: But his adviser?

Ms Shakespeare: We stay in regular contact with the minister's adviser about PBS listings that are being negotiated.

Senator WATT: I don't want to get this adviser's name, but what role do they have in the office? Are they a chief of staff or a senior adviser?

Ms Shakespeare: An adviser.

Senator WATT: Did the PBAC participate in these discussions with the minister's office?

Ms Shakespeare: No, the PBAC was not involved in any of these discussions. As I said, the advice that we provide to the minister about whether or not to enter into a deed under section 85E does not involve the PBAC unless we're look at recommending it under one of the SPA criteria that involves clinical factors.

Senator WATT: Were Boehringer Ingelheim ever part of these discussions that you had with the minister's adviser?

Ms Shakespeare: Not with myself or departmental officers, but they may have had separate discussions.

Senator WATT: You're not aware of whether they met with the minister's adviser about this?

Ms Shakespeare: Probably on several occasions, but I'm not able to confirm that.

Senator WATT: So that's about the listing. In terms of discussions that you had with the minister's adviser about Boehringer Ingelheim participating in the trial for the payments administration, it was you, your colleagues in the department, the minister's adviser, and not PBAC?

Ms Shakespeare: No. Discussions that we would have had with the company about the contents of their deed would not have involved the adviser. I would have separately spoken to the adviser about what was happening in the context of upcoming listings.

Senator WATT: And you haven't been part of any discussions with the minister's adviser about Boehringer Ingelheim's participation in the trial that have involved the company?

Ms Shakespeare: Not that I can recall at all, no. Again, it would be unusual.

Senator WATT: Has anyone in the department had any exchanges with Boehringer Ingelheim in which both the special pricing arrangement and the trial were raised, as opposed to discussions with the minister's adviser?

Ms Shakespeare: Quite possibly in terms of finalising the deed of agreement that was entered into by the Commonwealth and that company.

Senator WATT: Both topics came up in those discussions?

Ms Shakespeare: The deed of agreement would have included both the special pricing arrangement and clauses about future participation in the trial, so they would have been subject to the same agreement.

Senator WATT: Is the department aware of any exchanges between the minister or his office and Boehringer Ingelheim in which both the special pricing arrangement and the trial were raised?

Ms Shakespeare: No.

Senator WATT: So no new PBAC advice was obtained prior to this recommendation?

Ms Shakespeare: No. The company was not trying to argue that it had unique characteristics compared to alternative therapies.

Senator WATT: But there was never any PBAC advice to support the conclusion that the medicine should be recommended for listing in comparison with the medicine that has a similar arrangement?

Ms Shakespeare: At the time the medicine was recommended by the PBAC, the medicine was recommended for listing in comparison with the medicine which had a similar arrangement.

Senator WATT: So, despite the advice from the PBAC that this medicine did not have unique characteristics, the minister ignored that advice—

Ms Shakespeare: Recommendation (ii) says:

… unique characteristics compared to any available alternative therapies OR—

and there is clearly an 'or' in that criteria—

the medicine is recommended for listing in comparison with a medicine which has a similar arrangement …

Senator WATT: What are the risks? You said earlier that you're not aware of any SPAs that have been granted without PBAC advice, and I'd imagine that would normally be fresh advice.

Ms Shakespeare: This is a highly unusual circumstance for this medicine. I'm not aware of any other situations where this sort of thing has happened, where a medicine has been

recommended with a SPA which was then approved by the pricing authority but has then been prevented to list because other companies have withdrawn their SPAs.

Senator WATT: So it's a highly unusual situation.

Ms Shakespeare: I think it's a highly unusual situation, but now that we've seen it, looked at it and identified that the criteria probably need to be clarified to address what happens in this situation, we have agreed to work with Medicines Australia to review the criteria. As I said earlier, they date from 2009. They need to be updated to reflect significant policy changes that have happened since. They were developed at a time when there was much clearer ability to reference prices between medicines. Since 2015 we've been introducing price policies into the F1 formulary that prices medicines based on the time that they've been listed on the PBS, so the criteria will need to be updated to take that into account. We're also now moving to significantly different arrangements for medicines with special pricing arrangements in terms of us directly making payments of effective prices to manufacturers. So we'll deal with this ambiguity, we'll deal with the policy changes and we'll come up with new, clearer special pricing arrangements criteria in consultation with industry.

Ms Beauchamp: To take account of these very unusual circumstances that we've been facing.

Senator WATT: Sure. Why did you use, if I can call it, criterion (ii)(b) and the similar medicine erlotinib to give GILOTRIF a special pricing arrangement in 2018, but didn't use that in the previous attempts to have this listed in 2014, 2015, 2016 and 2017?

Ms Shakespeare: I'm unable to comment on the decision-making process back in 2014. When the company applied to us in late 2017 we looked at its application and at the criteria and we came to this decision.

Senator WATT: Is there anyone who was involved in those previous decisions who is here who can explain the difference in approach?

Ms Shakespeare: Clearly the criteria were interpreted a different way by the staff, but I think there is ambiguity in the criteria and we need to deal with that ambiguity. But, in the current instance, the way that we have applied the criteria has resulted in the listing of additional medicine available to people with advanced or metastatic non-small-cell lung cancer.

Senator WATT: Does erlotinib still have that special pricing arrangement in place?

Ms Shakespeare: Erlotinib does not.

Senator WATT: How is it then that you can rely on 2B, which is only available for a medicine that's recommended for listing in comparison with a medicine which has a similar arrangement?

Ms Shakespeare: If you look at the words, it could be interpreted a couple of ways. The medicine is 'recommended for listing', which seems to be the operative part of the sentence, 'in comparison with a medicine which has a similar arrangement'.

Senator WATT: Yes.

Ms Shakespeare: It was recommended. The criteria does not go on to say, 'and that similar arrangement must stay in place forever more'.

Senator WATT: But it says, 'in comparison with a medicine which has a similar arrangement'—presently, not 'had' in the past.

Ms Shakespeare: But, at the time of the PBAC recommendation, it did say 'had'.

Senator WATT: So you're saying that the date we need to be looking at is the date of recommendation for listing rather than the date that the new application is made? Years could pass since that recommendation is made and it's okay to rely on that and the comparison to a medicine that had an agreement in place then that might have elapsed?

Ms Shakespeare: I think we have to read what the criteria say. It's clearly a point of ambiguity that we will need to address.

Senator WATT: As you say, it does seem to be a very unusual arrangement. As you are probably aware, the recommendation for listing of this drug has been seen as highly questionable, given, at the very same time, this company is offering to participate in a trial of a new program that—

Ms Shakespeare: Many—

CHAIR: Senator Watt.

Ms Beauchamp: I think Ms Shakespeare has absolutely gone into comprehensive detail about the process. As a department, we've looked at the special pricing arrangements criteria and provided advice to the minister based on that criteria. I think Ms Shakespeare did speak about the unusual circumstances and, if you look at the outcome of this in terms of providing a drug for people with lung cancer, it's a good outcome for patients. But I just want to reassure you that we've gone through the advice, gone through the special criteria in providing our advice, and haven't been influenced on whether the company is participating in the trial or not.

Senator WATT: Okay, I hear what you're saying. I think that's it for that topic and 4.3.

CHAIR: I will ask a couple of questions to take us through to the break. Can you just run me through the total investments in medicine in this term of government, so since October 2013, in the PBS? Would you have that number available?

Ms Shakespeare: We do. Since October 2013, again at public prices, the overall cost of listings is around $9 billion.

CHAIR: And from this budget over the forward estimates?

Ms Shakespeare: In this budget, over the forward estimates, there is $1.4 billion for new listings in the budget, plus the $1 billion provision we were discussing earlier.

CHAIR: Is it three or four drugs that are new listings?

Ms Shakespeare: There are quite a few. We can go through some of the high-cost medicines listed in the budget.

CHAIR: I just want some global numbers, if possible. There's one I'm going to drill down on a little bit. But how many patients will benefit from the new listings?

Ms Shakespeare: We have a listing from 1 April for tenofovir and emtricitabine, to treat patients for pre-exposure prophylaxis of HIV infection. That will benefit around 32,000 patients, who would otherwise pay over $2,400 a year for that drug. That's actually the effective price of those listings because they are in F2 of $180 million.

CHAIR: So that's $32,000.

Ms Shakespeare: There's also the listing for nusinersen, a drug to treat around 160 patients per year with types 1, 2 and 3a spinal muscular atrophy. That's a very high-cost drug. They would otherwise be required to pay more than $367,850 per year.

CHAIR: Sorry, is that Spinraza? That's the trade name?

Ms Shakespeare: That's the trade name for that drug, nusinersen, and that's a total cost of $241 million public. There is also a commitment to list ribociclib, which is to treat certain types of inoperable or metastatic breast cancer, benefiting an average of about 3,150 patients a year who would otherwise need to pay over $71,820 for that medicine. That's a total listing cost of $703.6 million at published prices. I'm not sure if there are any others you're interested in.

CHAIR: I think that's it, isn't it?

Ms Shakespeare: Those are probably the three highest ones.

CHAIR: Yes, they're the three largest ones. Just in the interests of time, I'll put a few other questions on notice. Minister, we just want to confirm that the government's commitment to the PBS is demand driven and it is a fully uncapped program.

Senator McKENZIE: It is.

CHAIR: Thank you all very much. On that basis, we'll finish with program 4.3 and, insofar as we can release the officials, we will. After lunch we will move to program 4.4, Private health insurance.

Proceedings suspended from 13:16 to 14:17

CHAIR: We are ready to resume. We are on program 4.4, private health insurance. Senator Watt, are you ready to go?

Senator WATT: Thank you. The government has obviously made a lot of reforms, which it has announced, in the private health insurance sphere. Which of the government's reforms will have a new downwards impact on prices in 2019?

Mr Maskell-Knight: There are a number of reforms. The minister announced reforms on 13 October last year. The ones that are expected to have downwards pressure next year are introducing discounts for 18 to 30 year olds, if insurers wish to offer that, and the Prostheses List benefit reductions, which were implemented and took effect in February this year. There are several tranches in those reductions. Also, increasing the maximum permitted excess levels for products that provide an exemption from the Medicare levy surcharge.

Senator WATT: Okay. So they are the reforms in their totality?

Mr Maskell-Knight: Those are the ones that are going to potentially make premiums lower than they otherwise might be. There are a range of other reforms.

Senator WATT: Is it expected that those reforms will commence having a downwards impact on premiums in 2019?

Mr Maskell-Knight: The prostheses benefits have already had a downwards impact. They will have a continuing impact next year, as will the excess and, potentially, the discounts.

Senator WATT: How much of an impact do you say changes to the Prostheses List has had?

Ms Shakespeare: It is $188 million in the reductions that were put in place on 1 February this year, and they continue in future years.

Senator WATT: That is a total reduction in premiums for—

Ms Shakespeare: It is a total reduction in the benefits that private health insurers need to pay for prostheses. So that is the total savings to the insurers, which has flowed through to reduced premium increases.

Senator WATT: How confident are you that that has been passed on?

Ms Shakespeare: Absolutely confident, because we could identify it from the premium submissions that were submitted by insurers for the last premium rounds.

Senator WATT: Sorry, to confirm, you are saying that there has already been some impacts as a result of the Prostheses List changes and for each of the reforms you announced—discounts for 18 to 30 year olds, the Prostheses List and the increase to the maximum permitted excess—you would expect that they would have a downwards impact in 2019 and future years?

Ms Shakespeare: Yes. It is not that they are one-offs for a single year. The cumulative impact of the prostheses benefit reductions is in the order of $1.1 billion, in terms of lower benefits.

Senator WATT: Do you expect then that premium increases will be lower than 4 per cent in 2019?

Ms Shakespeare: I suppose that will be something we need to examine once we receive the premium application from insurers. That process hasn't yet started for next year.

Senator WATT: Was any modelling done? Does the department have any expectation of what the impact of those changes is going to be?

Ms Shakespeare: Our expectation, as always, is that the premium increases submitted by each insurer will be the absolute minimum necessary for them to operate their products.

Senator WATT: So you can't guarantee that as a result of these reforms the increase to premiums is going to be lower than 4 per cent in 2019?

Ms Shakespeare: I am not sure that it is the role of the department to offer guarantees on something like that.

Senator WATT: Well, these reforms were supposed to have a downwards impact—

Ms Shakespeare: And they are. We can give you numbers about the reductions in benefits that insurers need to pay. That will flow through to premium impacts.

Senator WATT: So if the reforms are going to have a downwards impact, you would then expect that the increases would be lower than 4 per cent in 2019.

Mr Maskell-Knight: I think it is safe to say that they will be lower than they otherwise would be. What drives premium increases is increases in benefits. And benefits are a function of the number of people insured, how often they go to hospital, what they go to hospital for, how expensive that is and a whole range of other imponderables. We cannot speak to what that is likely to be. We can only speak to what the effect of the regulatory action that has been taken will be.

Senator WATT: In the absence of any guarantees, then, it is possible that premiums will actually go back up to increases of 5 or 6 per cent next year?

Ms Shakespeare: It is simply not something we can speculate on. The department would at least need to see some submissions before we were willing to offer an opinion.

Ms Beauchamp: I think the bottom line is that all of the reforms that were mentioned last year were to keep that downwards pressure on premiums. As Ms Shakespeare said, some of those flow through not just on an annual basis but over the forward estimates.

Senator WATT: Okay. You said that you don't have any estimates or modelling based on the reform package that indicate the expected premium rises for next year.

Ms Shakespeare: No, we don't have any modelling about expected premium rises for next year.

Senator WATT: Do you think that there is any reason to hope that the rises might be as low as 2 per cent next year?

Ms Beauchamp: We have already said that this is all speculation and we are not in a position to say exactly what will happen, given the number of parameters that we have already spoken about. But we can say that the reforms already introduced will keep that downward pressure.

Senator WATT: Because you would be familiar that federal Labor is making a commitment to cap increases at 2 per cent. Given that we can't get any guarantees about 4 per cent, 5 per cent or 6 per cent, it is quite possible that Labor's policy to cap premiums would actually deliver lower price rises than would be delivered as a result of the government's reforms.

CHAIR: I think that the officials have indicated that they can't speculate on that.

Senator WATT: Minister, do you have a view on that? We haven't been able to get any commitments so far about health premium price rises next year. Are you able to give any commitment that the premiums will only rise by 4 per cent?

Senator McKenzie: Premium price rises will be a matter for the insurers themselves. But I think we are doing everything we can as a government to ensure that we put downward pressure on prices to ensure that the private health insurance market is as competitive as possible and that there are a range of products available for Australians to meet their needs.

Senator WATT: You might be doing a few things but you certainly haven't committed to a cap.

Senator McKENZIE: We are not North Korea, Senator Watt. We can't stipulate exactly what everybody has to pay for the one product that will offer—

CHAIR: Price controls have worked very well in the past, haven't they, Minister?

Senator WATT: So you think federal Labor's policy to cap health insurance rises is something more like you would find in North Korea?

Senator McKENZIE: No. What I don't think is that it will actually do everything that we have been able to achieve. And I don't think it is just me. The health industry itself and stakeholders have been very clear about the cap in that they don't think it will achieve the outcomes that you are hoping for either.

Senator WATT: Has the department provided any advice to government on federal Labor's commitment to premium rises?

Mr Maskell-Knight: I can't recall. I think we would need to go back and check the record.

Senator WATT: You don't remember having done that?

Mr Maskell-Knight: Not formal advice, no.

Senator WATT: Or one of these factual briefs that we heard about last night in another area?

Mr Maskell-Knight: There may have been, but I am not aware of that.

Senator WATT: Could you take on notice if that has happened?

Mr Maskell-Knight: I will take that on notice.

Senator WATT: We might leave it at that for private health insurance.

Senator McKenzie: You don't want me to read in what the AMA thinks about your policy?

Senator WATT: Well, I don't think they compared it to North Korea.

CHAIR: I would like to hear that, Minister. Please tell us.

Senator WATT: Before you arrived, Senator Singh, our policy was compared to North Korea.

Senator McKenzie: No, what I said was price controls and seeking to stipulate one product for the market. I think what we are doing in terms of keeping it competitive and ensuring that there are options for Australians across a range of price points is exactly the right policy to adopt. Dr Gannon, the President of the AMA, also warned that the 2 per cent cap could mean doctors were squeezed if insurers went harder on hospital contracts, 'which could lead to greater out-of-pocket costs for patients. ' He went on

> I worry that where this plan potentially lands is a further reduction in the quality of the product.

He said on Twitter at 12.30 that a standalone 2 per cent cap will exacerbate problems and do nothing to improve the value proposition of private health insurance, the health system and investment, not a cost. We could go to Mark Fitzgibbon, CEO—who is Joel Fitzgibbon's brother, I think—who labelled the ALP plan a 'reactive pre-election thought bubble' that doesn't make economic sense. I am really happy to go through what health stakeholders think to the two per cent cap.

Senator WATT: I'm not surprised that insurers don't want to see their premiums capped.

Senator SMITH: What did the teacher's union have to say. Too close to home?

Senator WATT: I didn't think you liked unions.

Senator McKenzie: Tell me, Senator Smith, what did the teacher's union have to say about private health insurance?

Senator SMITH: I'm not yet on that side of the table, Senator McKenzie.

Senator McKenzie: Anyway, I think it is clear that it is not all beer and skittles for health stakeholders when it comes to the Labor Party's approach to private health insurance.

Senator WATT: People I talk to are pretty happy about having their premiums capped.

Senator DI NATALE: What is the value of the PHI rebate? Do you have an update since the February estimates?

Mr Maskell-Knight: It is estimated for 2017-18 to be $6,258,000.

Senator DI NATALE: How does that compare with previous quarter?

Mr Maskell-Knight: That is for the year.

Senator DI NATALE: And the previous year was?

Mr Maskell-Knight: It was $6,239,000.

Senator DI NATALE: And if you are going quarter by quarter?

Mr Maskell-Knight: I'm going year by year. I don't have quarterly.

Senator DI NATALE: What is it projected to go up to next year?

Mr Maskell-Knight: At the moment the rebate is projected to be $6.406 million next year.

Senator DI NATALE: Have the recent changes to PHI had any impact on premium increases?

Mr Maskell-Knight: The changes that were announced by the minister in October last year?

Senator DI NATALE: Yes.

Mr Maskell-Knight: The most significant impact to flow through so far is a reduction in the prostheses benefits. As Ms Shakespeare said, perhaps before you came in, we are absolutely sure that that was passed on in the from of lower premiums from 1 April this year.

Senator DI NATALE: How can you be sure of that? What is the evidence for that?

Ms Shakespeare: It was identified in the premium submissions—the reduction in benefits paid for prostheses that were included in the forecasts.

Senator DI NATALE: Can I ask about coverage? These are the sorts of questions I ask at every estimates. How are we going with coverage?

Ms Shakespeare: In the March quarter there were 11.3 million people with hospital cover, which was an increase of 10,481 people insured from the December quarter.

Senator DI NATALE: So that is hospital.

Ms Shakespeare: For general treatment it was 13.5 million people, which is an increase of 46,792 people insured from the December quarter.

Senator DI NATALE: So an increase in 10,000 in hospital, and in general an increase in 46,000. How do you account for that, given that we have seen downward coverage? The trend has been going in the opposite direction?

Ms Shakespeare: The trend, if you look at the proportion of people with private health insurance, has been going down. But we have seasonal movements in people who have private health insurance. Hopefully, some of the reforms that we are making to private health insurance have been looked at favourably by people considering taking up private health insurance.

Senator DI NATALE: When you say 'seasonal', are you saying that for some reason, in the quarter that you have just described, you would expect to see an increase based on previous years?

Ms Shakespeare: These are all decisions that people make, based on their own personal circumstances, about whether or not to take out private health insurance. I think there probably would be changes if you looked at this over the course of the year.

Senator DI NATALE: So total coverage has gone up, but—

Ms Shakespeare: The number of insured people has gone up.

Senator DI NATALE: Yes, and that is reversing a trend that we have seen in previous quarters.

Mr Maskell-Knight: In terms of hospital insurance, it has been bouncing around a bit over 11.3 million for the last three quarters, I think, now.

Senator DI NATALE: And what about general?

Mr Maskell-Knight: It is much the same. I think this is possibly the most significant upwards movement for a year.

Senator DI NATALE: What about complaints? Do we have an update on complaints to the ombudsman?

Ms Shakespeare: Yes. We now have the most recent quarterly update from the Private Health Insurance Ombudsman. From the 1 January to 31 March quarter there were 1,211 complaints, which was a 14.5 per cent reduction on the same quarter last year.

Senator DI NATALE: How does that compare with previous quarters?

Ms Shakespeare: As the Private Health Insurance Ombudsman explained in their quarterly update in a lot of detail, they get most of their complaints in this quarter, because this is when people's premium increases are advised. It is an increase of about 29 per cent on the previous quarter, but they would expect to see in this quarter a lot more complaints, which is why they compare it with the same quarter last year. So, again, there are seasonal variations in complaints that need to be taken into account.

Senator DI NATALE: So what you're saying is that the 1,200 was an increase of 29 per cent in the September to December—

Ms Shakespeare: It is 1 October to 31 December. But the Private Health Insurance Ombudsman has explained—

Senator DI NATALE: Yes, I get your point; it's 29 per cent, and compared to the corresponding quarter—

Mr Maskell-Knight: It is a 14.5 per cent reduction.

Senator DI NATALE: Have you got a breakdown?

Mr Maskell-Knight: The ombudsman's report gives a breakdown, and that's publicly available on the ombudsman's website.

Senator DI NATALE: You haven't got headline categories for those things?

Ms Shakespeare: I just have the overall numbers, because I know that you ask for them.

Senator DI NATALE: Thank you. Have you got the average out-of-pocket cost per episode or service according to the latest figures—hospital and general?

Mr Maskell-Knight: For the latest quarterly statistics released earlier this month, average out-of-pocket for hospital treatment in the March quarter was $316.57, for hospital substitute treatment it was $8.95, for general treatment or ancillary benefits it was $47.85 and for medical services where a gap was payable it was $166.98.

Senator DI NATALE: Can you let me know how they correspond to the previous quarters?

Mr Maskell-Knight: The change from the previous quarter for the previous year, for March 2017, for hospital treatment it was minus 0.4 per cent, for hospital substitute treatment it was an increase of 80.4 per cent—but that means it basically went from $5 to $9—for general treatment it was an increase of 0.3 per cent and for medical gaps it was an increase of 12.3 per cent.

Senator DI NATALE: Okay. But it was broadly steady in most of those other categories. Have you got an update on where we are up to with the reforms around gold, silver and bronze?

Mr Maskell-Knight: There has been a lot of work done through the Private Health Ministerial Advisory Committee. There has been consultation with the sector on a number of occasions. We are moving towards being able to provide advice to the minister about what decisions he might like to make about the final design.

Senator DI NATALE: How far away are we, though? It's been a while.

Mr Maskell-Knight: Well, it is not a simple task.

Ms Shakespeare: These are to be in place from 1 April next year.

Senator DI NATALE: When do you expect you will be providing a recommendation to the government?

Mr Maskell-Knight: We are hoping that the rules embodying this will be in place certainly by the end of July, which will be in time for insurers to take that into account for their premium setting for next April.

Senator DI NATALE: And no move when it comes to the issue of junk policies?

Mr Maskell-Knight: I thought we had agreed not to use that word.

Senator DI NATALE: You might have agreed; I haven't. I don't think consumers have either.

Ms Shakespeare: It is not a category that appears in our structure.

Senator DI NATALE: But you are not going to exempt some policies from the rebate?

Mr Maskell-Knight: No.

Senator DI NATALE: No matter how meaningless they might be.

Mr Maskell-Knight: Every policy that is purchased contributes $800 to the risk equalisation arrangements. So hypothetically—

Senator DI NATALE: So it is basically a voluntary contribution. It is not an insurance policy; it's a tax contribution.

Mr Maskell-Knight: You might think of it that way, Senator.

Senator DI NATALE: I suspect that is how patients feel. We have dealt with medical devices. I want to talk to you specifically about the increase in hospital treatment coverage. Looking at the March 2018 AHPRA statistics, the largest increase in hospital treatment coverage was just 9,000 people, for people in the 70- to 74-year-old category. But in the 20- to 34-year-old category there was a loss of about 15,000 people. So, going to the question about the distribution of those coverage rates, if your increase in people is in the age category 70 to74, where you have plus 9,000, but you have a drop of 15,000 people in the 20- to 34-year age group, isn't that going to put further and significant upward pressure on premiums?

Mr Maskell-Knight: One of the reforms that the minister announced last year was to allow insurers to offer discounts to people aged under 30 to encourage them to join insurance and reverse that trend.

Senator DI NATALE: But there has been a significant trend in that direction.

Mr Maskell-Knight: That reform doesn't take place until 1 April next year.

Senator DI NATALE: Yes, but let's just assume that it is not going to make a significant difference. Let's just deal with the reality. The reality is that we have younger, fitter, healthier people dropping out. I suppose we could go back to that question about coverage and whether you can break that down according to age categories. For example, I imagine the increase in the 46,000 is skewed towards those older age groups.

Ms Shakespeare: What is published in the AHPRA statistics is probably what we can give you. The government is putting in place a range of reforms to try to make private health insurance more attractive and easier to understand, including a range of reforms that will benefit young people, to encourage more young people to take out private health insurance coverage. There are the discounts that Mr Maskell-Knight mentioned. We have also put in place changes to allow one-off upgrades so that people get more comprehensive mental health coverage. That took effect from 1 April. There will be other reforms as we roll them out that I think will address some of the issues that may have been impacting on people's views on whether or not to take out private health insurance.

Senator DI NATALE: Have you done any work to look at what impact the discounted premiums will have in terms of uptake?

Mr Maskell-Knight: It is very hard to model behavioural changes of this sort. A lot depends on how insurers react. Certainly the insurance industry are optimistic that they will be able to get significant numbers of younger folk in.

Senator DI NATALE: You said how insurers react.

Mr Maskell-Knight: Well, first of all, it is not compulsory to offer these discounts. Secondly, I suspect some of them are much better marketers than others.

Senator DI NATALE: Have you done any work to actually look at the impact?

Mr Maskell-Knight: We haven't done any modelling of what we think the impact will be.

Senator DI NATALE: I know modelling has a very specific definition in these settings, so I have not used the word 'modelling' deliberately. Have you done any work in this area to look at what impact it will have?

Mr Maskell-Knight: We've done some sensitivity about, if you assume so many people, what the impact is going to be. But we do not have the capacity to do behavioural analysis of 18- to 30-year-olds.

Senator DI NATALE: I'm not asking that. I am asking about the work that you have done. Based on the work that you have done, what conclusions have you drawn? What impact do you expect it will be?

Mr Maskell-Knight: The more young people you get in, the lower premiums are going to be.

Senator DI NATALE: Thank you. I'm talking specifically about what impact the decision to allow insurers to offer discounts to younger people will have on coverage?

Mr Maskell-Knight: I'm not trying to be cute. What I am saying is that we have said that, if this is the effect on people, these are the consequential downstream impacts. It is essentially set a sensitivity analysis. It is not trying to model what is going to—

Senator DI NATALE: You have said that there are a whole range of scenarios that could happen—

Mr Maskell-Knight: Yes.

Senator DI NATALE: and this is the impact that it will have, but we can't tell you what scenario will actually materialise. Is that what you are trying to say?

Mr Maskell-Knight: Correct.

Ms Shakespeare: The insurers are the ones who I think probably have a better idea about how they will market and develop their products to be attractive to younger people. They have assured us that in many cases they think it will allow more young people into private health insurance. That has been supported by the government in this package of reforms.

Senator DI NATALE: Just in terms of the average treatment episodes, if you are in that 70- to 74-year-old group, what is the average number of treatment episodes versus somebody in the 20- to 34-year-old group?

Mr Maskell-Knight: I don't know about the number of treatment episodes, but broadly speaking it is about five times the level of benefits paid every year.

Senator DI NATALE: The cost, yes?

Mr Maskell-Knight: Yes.

Senator DI NATALE: Five time the cost?

Mr Maskell-Knight: Five or 5½ times.

Senator DI NATALE: I can see why you are trying to get young people in to buy a product that they won't use.

CHAIR: I will take that as a comment, Senator.

Senator McKenzie: Thank you, Chair.

Senator DI NATALE: I want to go back to something we started the session off with yesterday, which is the questions of booking fees. Mr Maskell-Knight, can you tell me why the insurers haven't been more active in pursuing surgeons who charge booking fees, which are basically an additional cost for nothing?

Mr Maskell-Knight: I can't, Senator. I can't speak for them.

Senator DI NATALE: Can you just shed some light, because I don't feel that we got very far with this yesterday?

Mr Maskell-Knight: I would be theorising, and I am adverse to theorising in front of Senate committees.

Senator DI NATALE: Here we have a problem, which is a government initiative with private health insurance coverage. One of the reasons that people are dropping out is that they are being slugged with huge out-of-pocket costs. One of those costs is that some doctors are deciding to charge a fee that is not based on the service but just because they can charge it—or at least they feel they can charge it and get away with it. I can't understand how they can get away with it and I am asking you, given that it does have an impact on coverage—and obviously a significant impact on the work that you are doing, and obviously you are looking at reforms in this space to increase coverage—if one of the reasons that coverage is declining is out-of-pocket costs like this, why has it been allowed to happen for so long?

Ms Shakespeare: I think this is something that really needs to be asked of the insurers, who have the contracts that may or may not allow these charges to be put in place. The contractual relationship is between the insurers and the doctors. As Professor Murphy went through in a lot of detail yesterday, we certainly think that this is a problem.

Prof. Murphy: Senator, with respect, I think what I said yesterday was that, in my discussions with insurers, they find it very hard to get that information from their customers because—

Senator DI NATALE: *Four Corners* had no problem.

Prof. Murphy: if the customers provide that information, then the insurer, in theory, has the right to reduce the benefit paid to that customer.

Senator DI NATALE: But that is theoretical.

Prof. Murphy: No, it is in fact a practical risk.

Senator DI NATALE: It is in the interest of the insurer to stamp out booking fees. It's absolutely in their interest.

Prof. Murphy: That is exactly what our committee is achieving to do.

Senator DI NATALE: I know that is what you are trying to do. We had two Senate inquiries, as I said, both of which I participated in, where people felt very free to come forward and describe their experience when it came to booking fees. We obviously had that episode on *Four Corners* on Monday night when people volunteered that they had been charged these fees. It is not in the interest of the insurers for this to happen. It is not in the interest of government for this to happen because people are dropping out and you guys are now looking at a whole range of things to try to increase coverage. Why is it happening?

Prof. Murphy: The insurers tell me that they have tried to get this information from their customers and many are reluctant. Some of them are actually not even aware of what was paid as a booking fee. We are actually planning a survey with private health insurance to try to get some real data on this. We do not even know the extent of it at the moment. But, as I said yesterday, one of the clear commitments from government and from all of the medical

leaders is that this practice will be stamped out. We are going to work out a way of stopping it because it is unacceptable.

Senator DI NATALE: I think I'm done.

CHAIR: Senator Griff.

Senator GRIFF: It has been more than a year now since the government moved to cut prices on the Prostheses List. How many medical devices have actually had a price reduction so far? We know of the 2,400 medical devices delivered in February last year. How many more have been added since?

Ms Shakespeare: I think the price reductions that you are referencing were from 1 February this year. There were some previous reductions as well.

Dr Rothenfluh: The Prostheses List is fairly large. It has around 11,000 products. As an example, in February we added 410 new products to part A of the Prostheses List. The reductions applied to a whole range of products. I can't give you a figure on the exact numbers but it covers ophthalmic, ears, nose, throat, neurosurgical—for example cardiac products—as well as orthopaedic products.

Senator GRIFF: So there have been more than the 2,400 that were announced in 2017 added to the list?

Dr Rothenfluh: That sounds reasonable, but we would have to confirm that.

Senator GRIFF: If you could do that on notice, that would be great. What is the value of the savings so far?

Dr Rothenfluh: The savings in 2018 will tally up to $188 million. Over the four years, between now and 2021, we are expecting over $1 billion.

Senator GRIFF: Has the cost reduction resulted in any commensurate decrease in health insurance premiums for any insurer that you are aware of.

Ms Shakespeare: The premium increase this year was on average 3.95 per cent, the lowest premium increase in 17 years.

Senator GRIFF: So you would attribute that to the Prostheses List reductions?

Ms Shakespeare: They were definitely a factor that contributed to lower premium increases this year.

Senator GRIFF: Presumably, new devices will make up an increasing proportion of all devices used into the future, given how technology is changing. What processes are in place to keep the government's prosthesis reforms relevant and to ensure that the prices are competitive moving forward?

Ms Shakespeare: There are health technology assessment arrangements in place to ensure that when we list new products they have been assessed as clinically effective and cost effective. That sits under the Prostheses List Advisory Committee and its subcommittees. We also have a range of reform commitments that we have entered into as part of the government's compact with the Medical Technology Association of Australia, which will look to streamline and modernise the Prostheses List.

Dr Rothenfluh: That includes a review of the benefit setting model. It includes a review of the assessment processes and a review of the cost recovery arrangements that we have in place.

Senator GRIFF: What is the timeframe for these reviews?

Dr Rothenfluh: The agreement is in place until 30 January 2020. But there are specific elements of what we have to achieve that we have to do beforehand. For example, the process review and the cost recovery has to be done and in place by 30 January 2022. There is a staggered set of deliverables over that period. For the benefit setting mechanism review there is no timeline, but we obviously have to have that done before the expiry of the agreement, which is 2022.

Senator GRIFF: The *Review of the Australian government rebate on natural therapies for private health insurance* report, published on the department's website, summarises the findings of the overviews done for the 16 natural therapies. For transparency, will the original overview reports also be published for public scrutiny?

Ms Shakespeare: I believe that these reports were undertaken by the National Health and Medical Research Council office. I believe that we would need to refer that to them.

CHAIR: On that basis, we can release officers from program 4.4 insofar as they are not required later on. I believe that there are no questions for program 4.5, so we can also release officers from program 4.5: medical indemnity.

[14:54]

CHAIR: We will now move to program 4.6: dental services. I am just going to start off with a few questions and then I believe Senator Di Natale has a few questions. Can we have an update on where the national partnership agreement in the dental space is at the moment? How many states and territories have signed on, how many haven't and who has and who hasn't?

Ms Cole: All states bar Queensland have currently signed the dental NPA.

CHAIR: So everyone is on board except Queensland.

Ms Cole: That's correct.

CHAIR: What is the stated reason why Queensland is not on board?

Ms Cole: Queensland haven't given us a specific reason as to why they have not yet signed the NPA.

CHAIR: Okay. Obviously, nobody except Queensland could fall into this category, but has Queensland indicated that funding is insufficient to meet the costs of providing the additional services?

Ms Cole: No, they have not raised with us any issues around the costs given for each unit under the agreement.

CHAIR: So, if they were to sign the agreement, what would that unlock for Queensland and how many patients would that deliver services to?

Ms Cole: For Queensland, over the total amount of the NPA, it would unlock close to $49 million over the total time.

CHAIR: Is there any modelling on how many dental visits or procedures that would support?

Ms Cole: I can provide that kind of detail on notice for you, but the total value of services overall in all of the NPAs is around 400,000. So it would be their population share of that.

CHAIR: Again, there has been no reason given. Are negotiations ongoing? What is the state of play?

Ms Cole: The offer has been made to them and they haven't responded.

CHAIR: When was the offer made?

Ms Cole: It was back in June 2017, I believe, at the same time as all of the other states and territories.

CHAIR: So it was made almost a year ago.

Ms Cole: Yes.

CHAIR: Very interesting. Senator Di Natale.

Ms Beauchamp: I think the NPA formally commenced in October 2017, so June sounds right.

CHAIR: So the money could have been flowing for six months.

Ms Cole: Yes.

Senator DI NATALE: So you have offered them some money for dental services and they have said, 'No, we don't want the money'?

Ms Cole: They haven't responded.

Senator DI NATALE: That doesn't make any sense at all.

Ms Edwards: They haven't responded. We have from time to time spoken to them on the phone, saying, 'How are you going with the dental NPA?' and to date we don't have a clear reason why they haven't signed on to the NPA. The offer remains open.

Senator DI NATALE: At the moment, what are the waiting lists in Queensland like?

Ms Cole: We don't know, because part of the NPA—

Senator DI NATALE: Includes data on waiting lists, yes. Again, it is unprecedented as far as I can tell. I can understand if they have an argument over one aspect of the agreement, but you are saying that they haven't identified anything specific about the agreement that they are unhappy with.

Ms Edwards: Not that they've passed on to us, no.

Ms Cole: Not at an official level.

Senator DI NATALE: And you said that you had called them from time to time. When was the last time that you spoke to them?

Ms Edwards: We speak to the same officials who are responsible for that about other things regularly.

Senator DI NATALE: When was the last time you spoke to them about this?

Ms Cole: It was probably approximately three to four weeks ago, when I was last in Queensland.

Senator DI NATALE: And what was their response?

Ms Cole: They basically said that it was a decision of government and they had nothing further to offer.

Senator DI NATALE: Okay. I don't know if there is anything more to get out of that, but obviously that is a question for some of our colleagues in Queensland to pursue. What about the other states? You have struck the agreement. Can you outline the funding associated with that agreement?

Ms Cole: Would you like that by state and territory?

Senator DI NATALE: Yes, thank you.

Ms Cole: The funding under the NPA for New South Wales is a total of $77.3 million. For Victoria it is $60.5 million. For Queensland, should they accept it, it is $48.7 million. For WA it is $21.8 million. For South Australia it is $21.1 million. For Tasmania it is $7.6 million. For the ACT it rounds up to $2.2 million. For the Northern Territory it is $3.2 million.

Senator DI NATALE: What is the total?

Ms Cole: The total over the full life of the agreement is $242.5 million.

Senator DI NATALE: So the totals you have given me for each state are over the life of the agreement.

Ms Cole: Yes.

Senator DI NATALE: For what period?

Ms Cole: That's from January to March 2017 through to March 2019.

Senator DI NATALE: Sorry; January—

Ms Cole: The tables that I have use the figures that they have under the NPA. So the January to March period through to March 2019. We can clarify the numbers for you if you like for those financial years.

Senator DI NATALE: Again, if you can now, you are saying that is from—

Ms Cole: The figures I have in the table are from January 2017 to March 2019, according to this table

Senator DI NATALE: But you will clarify that?

Ms Cole: That is correct.

Senator DI NATALE: Is that $242 million minus the $48 million from Queensland?

Ms Cole: No, that is including the $48 million. I listed it for you and indicated that that is if they accept the offer.

Senator DI NATALE: If they accept the offer, the total value of the agreement is $242 million over, basically, a two year period?

Ms Cole: Yes.

Senator DI NATALE: Can you tell me about the previous agreement?

Ms Cole: What would you like to know about the previous agreement?

Senator DI NATALE: You don't have to give me a state by state breakdown. What was the value of the previous agreement?

Ms Cole: I don't actually have that with me. I can take it on notice. It is actually publicly available, so it will be on the website.

Senator DI NATALE: There is lots of stuff that is publicly available. But one of the advantages of Senate estimates is that we get to ask you something and you get to provide us with answers. I know that the department is always very keen to point us to documents that are publicly available but sometimes we just don't have the resources, particularly those of us in smaller parties, to be able to pursue all of that information on our own.

Ms Beauchamp: Sometimes the officers don't have this information.

Senator DI NATALE: I know. I appreciate that you don't have it at your fingertips, but I don't want to be made to feel guilty for asking for some information from the department.

Ms Beauchamp: We will take that on notice.

Senator DI NATALE: Thank you. Can we go to waiting lists state by state? Do you have that?

Ms Cole: We don't have complete waiting lists from all of the states and territories at this stage.

Senator DI NATALE: What have you got?

Ms Cole: The ones that we have are not for the full period, either. Under the agreement, they are required to provide their statistics to us. So we don't have a comprehensive set of waiting lists. I can provide what we have on notice. I don't have it in front of me.

Senator DI NATALE: Okay. So you will provide what you have on waiting lists on notice?

Ms Cole: That is correct. The advice has been provided to us by the relevant states and territories.

Senator DI NATALE: Do you have some current stats around the uptake of the Child Dental Benefits Schedule? Can you tell me the most recent information you have around the usage of the CDBS and over what period?

Ms Edwards: Our most recent is from 2017. It runs on a calendar year, this program. The figures, we think, have now settled, because some claims for 2017 come in late. Given that we are in late May we are probably pretty much at the end of any 2017 claims. The number of children accessing it in 2017 was 1,072,470. The overall take up rate is 36.3 per cent of eligible children.

Senator DI NATALE: That is for the 2017 calendar year?

Ms Edwards: Correct.

Senator DI NATALE: How does that compare with the 2016 calendar year?

Ms Edwards: It is an increase from 36.61 per cent in 2016. We have seen a gradual increase over recent years.

Senator DI NATALE: In terms of promotion, everyone who is eligible gets a letter at the start of the year, is that right?

Ms Edwards: They continue to get a letter, yes.

Senator DI NATALE: Is anything else being done to promote it?

Ms Edwards: There is a new social media campaign that we have been running this year. We understand it is contributing to the increasing rise and we are hoping that that will continue. The Department of Human Services also writes to dentists so that they can promote the service.

Senator DI NATALE: Do you have any information about the split in terms of public providers versus private providers and do you have that as a state by state breakdown?

Ms Cole: We did actually break that down for you at one stage. Sorry, it is a national figure.

Senator DI NATALE: If you give us the national figure and perhaps on notice if you could give us the breakdown that tells us a bit about what is going on in each state.

Ms Cole: Yes.

Senator DI NATALE: And the national figures for the public-private split?

Ms Cole: If you can just give us a moment. We will come back to the question if you like.

Senator DI NATALE: That is my last question on that. So I will just wait for that.

Ms Cole: This is the public-private breakdown for the Child Dental Benefit Scheme. Noting that if you, for example, get services through your school and your state, they are able to charge under certain circumstances. At the moment, in terms of patients for the period 1 January 2014 to 31 January 2018, the breakdown in 548,000 public and 1,797,780 private, giving a total of under 2.2 million. So in terms of percentages, the utilisation by sector is about 25 per cent in public and 81.9 per cent in private. Why that doesn't sum up properly is because people sometimes jump across both systems.

Senator DI NATALE: But broadly it is a quarter through school programs?

Ms Cole: Yes.

Senator DI NATALE: Through public dental programs?

Ms Cole: Yes.

Senator DI NATALE: Under specific circumstances?

Ms Cole: Yes. So you have to be eligible, obviously, under the normal arrangements and then the parent, usually, has to assign and basically enable the public system to be able to charge.

Senator DI NATALE: But the vast bulk are being delivered through the private providers. Good. Thanks.

CHAIR: On that note I shall release program 4.6, dental services, in so far as they are not required in the future. I don't believe anyone has questions for 4.7, health benefit compliance, so I shall release 4.7. We will n ow go to program 4.8, targeted assistance, aids and appliances. Senator Leyonhjelm, you have the call.

Senator LEYONHJELM: I will be quite brief. In previous estimates I have inquired about the GST treatment of sanitary pads and tampons. I was told that although notionally the minister has the power to make a regulation that would make them GST free, the consent of the states was required to achieve that. When condoms, lubricants and sunscreen were first made GST free, did each state agree to the change?

Ms Shakespeare: I am afraid that I am not going to be able to answer that question for you. It is probably something that could be referred to the Treasury, who have responsibility for the GST legislation.

Senator LEYONHJELM: Well, they are a bit inclined to refer it to you.

Ms Shakespeare: They are?

Senator LEYONHJELM: Perhaps you could take it on notice.

Ms Shakespeare: I am not sure that any of those products are covered under any of our targeted aids and appliances programs. In this area we fund things like bandages for people with epidermolysis bullosa. We have diabetes products under the national diabetes service scheme.

Senator LEYONHJELM: The analogy I drew was that products relating to a disability were GST free. I asked the question as to whether or not menstruation was a disability or if we could make it a disability so that it came under the same criteria. Can you think of anything that is GST free, any item that you would struggle to classify as being required for a disability?

Ms Shakespeare: I am really not certain around the GST status of products.

Senator LEYONHJELM: This issue seems to fall between the cracks. No-one seems to want to own it. My contention is that when it was decided that the GST was not applicable to a number of products, the states were not consulted. But that is a rebuttable presumption and I am seeking someone who is willing to rebut it.

Ms Shakespeare: I think that under the administered arrangement orders, the GST legislation and tax legislation, does belong to the Treasury.

Senator LEYONHJELM: I acknowledge that. I am just not convinced that the Treasury would make a decision without involving you folks fairly extensively. I doubt that they would make a decision by themselves. Some of the items are still subject to GST and some of them that aren't, in which case I would have thought would have come to the attention of your department.

Ms Shakespeare: I am not aware of any discussions we have had with the Treasury about the GST status or application on any health products.

Senator LEYONHJELM: There are some very wide cracks in some of these issues, and this is one of them. I might have to put some questions on notice to see if I can find somebody at least who is prepared to address the issue.

Ms Shakespeare: We will certainly see if we can help you.

Senator SINGH: Labor is addressing it. We are getting rid of the tax on it.

Senator LEYONHJELM: Well, that is a vote for me for the policy. I have a feeling that this refusal address the issue on the proposition that the states have to all agree is being used as a smokescreen. I suspect that there are products that have been exempted from GST by the minister which didn't involve the states all agreeing.

CHAIR: I think this might not be a questions, so we will move on.

Senator LEYONHJELM: I can turn it into a questions if you like.

Senator McKenzie: I think states are looking at this. In the appropriate forum this is a topic of active discussion.

Senator LEYONHJELM: What's the appropriate forum?

Senator McKenzie: When all of the state and territory treasurers get in a room.

Senator LEYONHJELM: Okay, I'm not getting anywhere so I won't turn it into a question. I will give up.

CHAIR: So is everybody very clear that we have finished with outcome 4? As there are no further calls, I can release program 4.8 and all of the remainder of outcome 4, where they are not required for later items, and we will move onto outcome 5, regulation, safety and protection.

Senator SINGH: We don't have anything in 5.1 but we do in 5.2 and 5.3.

CHAIR: In that case, we will begin with program 5.1, protect the health and safety of the community through regulation. Senator Di Natale.

Senator DI NATALE: I have questions on medicinal cannabis. My first question is around applications for medicinal cannabis received by the TGS under the Special Access Scheme category A and B.

Dr Greenaway: I will be able to answer that, although as you probably realise I was expecting Professor Skerritt to answer the regulatory aspects of medicinal cannabis.

Senator DI NATALE: Is he not available?

Dr Greenaway: As of about an hour ago he was heading here.

Ms Beauchamp: I think that this session was scheduled for 3.30 pm. We are running a bit ahead of schedule.

Senator McKenzie: Which is rare.

Senator DI NATALE: I was going to say! I think he can be forgiven for not being here early.

Ms Beauchamp: He is on his way. He is in the building.

Dr Greenaway: Since 1 January 2016, there have been 513 approvals in SAS Cat B. I do know that of the authorised prescribers since 1 January 2016 and 33 authorisations to 31 December 2017, 193 patients have been involved in those. You would be aware that the Authorised Prescribers Scheme does by its very nature involve a notification rather than individual approval. So we would expect that to be updated next month.

Senator DI NATALE: Of the 33 authorised prescribers, do you have a breakdown of their specialties?

Dr Greenaway: The majority that I know are paediatric neurologists.

Senator DI NATALE: But are there other specialities?

Dr Greenaway: I would have to take that on notice to give you the exact number, but I believe that palliative physicians are also amongst the authorised prescribers.

Senator DI NATALE: Do you have the number of rejections for all categories?

Dr Greenaway: The category B approvals turnaround time for the TGA is very rapid. On average it is about 48 hours. So, again, I would need to take that on notice and get back to you because I didn't expect to be answering questions on notifications.

Senator DI NATALE: Yes. That's alright. What about the authorised prescribers? How many prescribers have been rejected under authorised prescriber status?

Dr Greenaway: Again, I am not aware. The Authorised Prescriber Scheme, as you know, requires approval by either the appropriate college or a NHMRC ethics committee. Once that approval if given, the authorised prescriber is a formality.

Senator DI NATALE: So you wouldn't have access to people who have been rejected by the college?

Dr Greenaway: Not off of the top of my head, but we can get it.

Senator DI NATALE: Welcome, Professor Skerritt.

Dr Skerritt: Good afternoon.

CHAIR: Never doubt the efficiency of this committee.

Dr Skerritt: I may need oxygen. Thanks to the committee for creating history and actually running ahead of schedule. I believe the question was about rejections. There have been no rejections in the last couple of years. The rejections in the system related to before about 2015-16 when there were applicants for very poorly defined products and, obviously, the evidence base was very poor at that time. So there haven't been any rejections. When a clinician comes to us and it is a most unusual indication and they haven't provided evidence in support of the indication or if they haven't defined the product and just written 'medicinal cannabis', we go back to them and ask them for more information.

Senator DI NATALE: What about in regards to authorised prescribers? I am not sure what the paperwork looks like, but the college needs to sign off on it?

Dr Skerritt: A college or a society. So there is a wider range—for example, the National Institute for Integrative Medicine, which operates out of Victoria. I was speaking for two days at a medicinal cannabis workshop there recently. It is an authorised prescriber.

Senator DI NATALE: Wonders will never cease. You will be a convert soon. Did you have a good two days?

Dr Skerritt: It was very integrative, Senator.

Senator DI NATALE: You have thrown me now.

Dr Skerritt: On a more serious note, that course was actually accredited by the Royal Australian College of General Practitioners for CPD points. It is the first time a medicinal cannabis conference—

Senator DI NATALE: Where was that?

Dr Skerritt: It was at the National Institute for Integrative Medicine, but it was attended largely by GPs and pharmacists.

Senator DI NATALE: I don't know anything about the college. Where is it based?

Dr Skerritt: This is a group that involves physicians looking at the whole care of the patient. They might, for example, use remedial massage or acupuncture together with pharmaceutical therapies with patients.

Senator DI NATALE: The college is based where?

Dr Skerritt: It is in Hawthorn in Melbourne.

Senator DI NATALE: So the education that was provided—

Dr Skerritt: We have been involved in a dozen or more—that is probably an underestimate—educational events over the last year or so.

Senator DI NATALE: Which attract CPD?

Dr Skerritt: No, this is the first one. Because the awarding of a CPD is not our decision. Obviously it is the RACP, the RACGP, et cetera.

Senator DI NATALE: The colleges, yes. So who accredited it?

Dr Skerritt: This one was accredited by the RACGP for the CPD.

Senator DI NATALE: What was the course that was run?

Dr Skerritt: It was a course about medicinal cannabis indications.

Senator DI NATALE: Run by who?

Dr Skerritt: It was obviously co-sponsored by the Royal Australian College of General Practitioners, but it was also run by the College of Integrative Medicine and the Institute Of Complementary Medicine at the University of Western Sydney, which is probably Australia's strongest complimentary medicine research centre.

Senator DI NATALE: So does that mean that this course is now accredited to be run around the country? I'm just thinking, as a GP—

Dr Skerritt: They are looking at running it again in Sydney because it was oversubscribed. In fact, they could have had another dozen or two general practitioners. Especially because a lot of these courses are on weekends, we all take the short straw and take turns giving up our weekends to present at them.

Senator DI NATALE: I don't know what that's like. The course is now, as you say, accredited for CPD. Are there other accredited courses for GPs?

Dr Skerritt: My understanding is that this is the only accredited course. There was a one day course run in the ACT this last weekend. That wasn't an accredited course, I understand.

Senator DI NATALE: I understand that there were some American speakers involved, facilitated by the ACT government. Is that right?

Dr Skerritt: The ACT government had an involvement. We have actually been talking with them because there was a bit of misinformation about the process to access medicinal cannabis. There was misinformation such as us having a list of preapproved indications and so forth. After discussions with ACT Health, they will circulate a few corrections to the people who attended the meeting.

Dr Greenaway: Can I just make the comment that Associate Professor David Caldicott was involved in organising it. So that wasn't directly something the TGA had an input into. But members of the TGA went in a personal capacity and there have been a couple of issues that, as Professor Skerritt said, were errors in fact. We are going to write to the organisers and to Professor Caldicott to correct it. Professor Caldicott works at Calvary Public Hospital, which is part of ACT Health. So, yes, ACT Health was involved in that course, to my understanding.

Senator DI NATALE: If you are a GP working in Sydney and you want to get accredited for having done some professional development in this area, what happens next? Just to give some context, there are a lot of GPs who want to learn more about this and want to ensure that they are doing something that is accredited by their college and is recognised. At the moment there is not much out there for them to do. So I am interested to know, what is the next step?

Dr Skerritt: They have had such interest in this that they are going to run it again in Sydney. I think it is the first weekend in September and Professor Greenaway and I will probably toss a coin on that one. They are talking about running it in each capital city, depending on demand. It is a fairly modest fee, but obviously it has to recover its costs. I don't even know what fee is charged.

Senator DI NATALE: When you have completed the course, what does that give you apart from, obviously, a little more knowledge and satisfying your CPD requirements? From within the department, for example, if someone has completed the course are they more likely to get an application through? Does it give you, as the body that approves applications, some comfort? I mean, what is the value of doing this?

Dr Skerritt: You would say they are more likely to get an application through because they have attended a course and understood that certain indications have a stronger and clearer evidence base. They also were advised about the group of clinical evidence studies that were commissioned by the department and published on our website, together with over 200 research papers and the medical literature on the efficacy of medicinal cannabis. They will know about the existence of that information, because, as you have often said, the knowledge base is very scatty. There will, therefore, I hope, be fewer people who have their applications sent back with, 'Tell us a bit more about the evidence base. 'What we don't say is that just because you have done a course, tick. We do have a system, as you are aware, called the Authorised Prescriber Scheme where a prescriber, once they get an authorisation, can prescribe in that category to either one or 101 patients.

Senator DI NATALE: Will this increase the likelihood of them being approved as an authorised prescriber?

Dr Skerritt: I don't have a crystal ball. What I do know is that the organisation in Victoria has already—

Senator DI NATALE: Which organisation?

Dr Skerritt: The National Institute of Integrative Medicine. They have already acted as an ethics body for a well-known GP—and I won't name the GP; you can understand why—in Melbourne as an authorised prescriber for medicinal cannabis for certain conditions.

Senator DI NATALE: Is he or she the first GP to be approved as an authorised prescriber?

Dr Skerritt: I would have to take that question on notice. You are right in that most of the authorised prescribers are specialists—

Senator DI NATALE: Before you arrived we had that discussion. So it is mostly paediatric neurologists, some palliative care people—

Dr Skerritt: Paediatric neurologists and palliative care. Of course, palliative care is often the domain of GPs. Of course, GPs are specialists in life, according to the RACGP. But it is often GPs who are the ones who are seeing palliative care patients.

Senator DI NATALE: Just to be clear about this—and I know that it sounds very technical—but access is still a very big problem. Would you expect that if the National Institute of Integrative Medicine becomes a body that says, 'We are happy to certify you as an approved prescriber'—although obviously that is your decision, but if you get a recommendation from them, will they then be—

Dr Skerritt: The way it works now is that the appropriate college's—and this is a number of colleges and societies—ethics committee actually makes the decision. We check that the application is complete and in alliance with regulations, but we don't second guess. And authorised prescriber is actually—

Senator DI NATALE: So you are a rubber stamp, really?

Dr Skerritt: When it comes to authorised prescribers, we are a rubber stamp if it is complete.

Senator DI NATALE: So this college or institute could become the vehicle through which GPs become authorised prescribers?

Dr Skerritt: They could be one of a number of vehicles. I don't have a list of accredited organisations for authorised prescribers, remembering that this is a broader system used for hundreds of different medicines every year. There is nothing, for example, that would stop, say, a palliative care college or some discipline speciality also having that. I would imagine there would be a number of GP members of a palliative care association or society.

Senator DI NATALE: What does that National Institute of Integrative Medicine require of a GP to issue them with authorised prescriber status?

Dr Skerritt: The requirements for authorised prescribers are documented. They are both our requirements and the NHMRC's requirements. Effectively it is a duly constituted ethics committee. The NHMRC have fairly detailed guidelines on what is required in terms of the skills of the members of the ethics committee, what considerations they have to go through and what evidence they have to look at.

Senator DI NATALE: I want to be practical here. I'm a GP. I'm working in the community, this is an area of interest, I've done this accredited course and I say, 'Patients are contacting me regularly, and, rather than having to put an application in for each patient, I want to be an authorised prescriber so that I don't have to do that anymore; I can just prescribe.'

Dr Skerritt: You can put your submission in to the committee I just mentioned, as did a suburban Melbourne GP.

Senator DI NATALE: So it's a submission to an ethics committee?

Dr Skerritt: Correct. It's a reasonably detailed submission, but it's a one-off. The GP puts a submission in describing the patients, describing how they're followed, describing the product and describing the indications. That's then considered by a committee duly set up by the relevant college or society. There may be dialogue between the committee and us, especially if it's a committee that hasn't done many of these, but the actual decision is made

by the committee. We rubber-stamp it, to use your words, to check that it conforms with all the legal requirements, but it's actually the committee standing in review—

Senator DI NATALE: This stuff often falls down on the detail. It sounds reasonably straightforward in practice, but the nature of the submission might be enough for GPs to say, 'I'm just not interested; it's too difficult.'

Dr Skerritt: The guidelines from this particular college are on the internet. They've written their own guidance material, and, again, I can take on notice the web link—

Senator DI NATALE: No, that's good. I'll jump online.

Dr Skerritt: I wouldn't be surprised if some of the other GPs who attended this course in Melbourne or who are attending the one in a couple of months time in Sydney also go through it. There was actually a training session at the workshop on 19 and 20 May on training GPs and others on how to apply—noting that you have to be a registered medical practitioner.

Senator DI NATALE: That's progress, albeit slow.

Senator LEYONHJELM: Isn't it effectively a trial?

Dr Skerritt: No, it's not a trial. It's an approval to use an unregistered medicine. It's an approval. You write a normal prescription in the usual way, except it's a prescription for an unauthorised medicine and it goes through the authorised prescriber pathway.

Senator LEYONHJELM: Which involves an ethics committee?

Dr Skerritt: It involves that. The reason an ethics committee is involved is the medicine hasn't been assessed for safety, quality and efficacy by the TGA, as opposed to medicines that are on our register and all the medicines on the Pharmaceutical Benefits Scheme list.

Senator DI NATALE: Do you know if any other colleges are looking at the same process?

Dr Skerritt: There are now 33 different physicians authorised for 39 different conditions. Someone may have an authorisation for pain and palliative care. I know a physician who does have two. Those physicians will have been through different committees. I'm not sure how many different committees that adds up to, but several committees have assessed medical cannabis proposals for a range of conditions. Yes, the largest number are for epilepsy, but there are some for neuropathic pain, palliative care, intractable pain and so on.

Senator DI NATALE: Obviously the other issue is the layer of state regulation. Coupled with the hoops that need to be jumped through at a federal level, there are a whole lot of state regulations. Do you know of many instances where you've approved—not through the authorised prescriber pathway but through the other pathways—a prescription for an individual patient that was then blocked at state government level?

Dr Skerritt: There have been a couple of cases that were well publicised in New South Wales and Tasmania. You may be aware that ministers, state and territory and Commonwealth, met at COAG Health Council in April. At their ministers-only meeting, they discussed this issue, and they also discussed the need to streamline and avoid duplication between states and territories. There was an announcement made by Minister Hunt—it's in the public domain—on 13 April. Since that time, we've been working together with the states and territories. On 2 March, Minister Hazzard and Minister Hunt, jointly announced—I know because I was there, together with the Chief Health Officer of New South Wales—that New

South Wales wouldn't be second-guessing or assessing the clinical suitability of a cannabis product, except to the extent that states have to, by law, look at schedule 8 controlled drug issues. That's separate from the special assessment of cannabis. Since that time, we've done a very significant number—I think it's somewhere between 100 and 200—New South Wales applications, all within under 48 hours.

Senator DI NATALE: What was the basis of the rejection at the time?

Dr Skerritt: Mainly on indications in the states and territories. In New South Wales—this is, again, prior to 2 March; there haven't been any rejections since 2 March, and the system's been working beautifully. Tasmania is an interesting situation. I'm sure I'm not the first person to say that.

Senator SINGH: Interestingly disadvantaged.

Dr Skerritt: On one hand, they're interestingly advantaged, because in Tasmania the government has made a commitment to fund access, through compassionate schemes, for medicinal cannabis.

Senator SINGH: At snail pace.

Dr Skerritt: On the other hand, it's a very small number of patients. One of the discussions that is underway is about, if someone off their own bat wanted to access medicinal cannabis and realised they might not get funded by the government of Tasmania, whether the government of Tasmania would be willing to do that. Discussions are continuing at officials level, and I know that they're also continuing between the ministers' offices.

Senator DI NATALE: Average time—you say you've got a 48-hour turnaround.

Dr Skerritt: Less than.

Senator DI NATALE: But that's your end of it. Then there is state approval.

Dr Skerritt: What happens with the state approvals with New South Wales—I can talk about that one because it's been up and running now for almost three months, come mid-June—is that the New South Wales approvals are nested within ours. We'll get the application electronically from the doctor. If it's a schedule 8 product—and again this is all going to be automated through a portal, but at the moment it's manual, as far as email's concerned. We'll whiz an email off to New South Wales Health if it's a schedule 8 product, and consistently—as I said, 100 to 200 times, so they've kept their word—they'll do the relevant schedule 8 approvals. They're about whether the doctor has any funny history to do with questionable prescribing of drugs of addiction or whether the patient has a history of going from doctor to doctor, doctor shopping. Each of the 100 to 200 times in New South Wales, since 16 March, when the scheme started to roll out, have all been done within that 48 hours. It hasn't been additional—

Senator DI NATALE: So it's not additional. What about other states?

Dr Skerritt: Other states are a work in progress. There have been several meetings—

Senator DI NATALE: That's a euphemism for 'you're not getting anywhere'?

Dr Skerritt: No. Victoria and Queensland, of course, have the challenge that they have actually legislated medicinal cannabis schemes. Repealing legislation obviously requires a slot in their parliament, and Victoria, for example, only have about 20 sitting days till their election. But Victoria, we believe, will be on board very soon, and we are slowly—as quickly

as we can; maybe the slowness is on their side—working with other states to catch up. As always, the devil is in the fine detail. Some states have particular rules about not being able to disclose patient information outside their state, and so they've got to go to their Attorney-General's or their justice department and get advice on the legality of giving us that information. We're working there. Minister Hunt has a very strong interest in this. In fact, I understand that the letters are up with his office to send to ministers, encouraging them to continue with this commitment.

Senator DI NATALE: So at this stage, if you're in New South Wales, there's not a parallel process—or there is, but it's nested—

Dr Skerritt: It's invisible.

Senator DI NATALE: It's invisible because it happens within the same time frame—

Dr Skerritt: Within the 48 hours.

Senator DI NATALE: But in other states that doesn't happen, and so it can take weeks. I know you keep saying within 48 hours, but from the time a doctor writes a script to when the very few number of patients who are able to access it access it it can be weeks—yes?

Dr Skerritt: It depends what they're after. Despite the rest of civilisation walking away from fax machines, we know that doctors still use fax machines a lot. Even so, if a doctor faxes it to us, and we can receive faxes—I had to explain what one was to my 20-something-year-old daughter!

But we can receive faxes. That fax goes into the electronic system, and the 48-hour clock starts then. If they're requesting one of the products that's available ex-stock—and as I've said in this place before, there are a number of products where stocks of them are in capital cities and secure pharmaceutical warehouses—they're generally dispatched within 48 hours. It need not be a matter of weeks.

Senator DI NATALE: It can be, but it often isn't.

Dr Skerritt: That's a commercial matter, from when a company gets an order to when they dispatch it, but most companies want to see cash flows, so they do dispatch product.

Senator DI NATALE: Cost is the other issue. We hear in reports that it's prohibitive for a number of patients. Is anything being done to try and bring down the cost for patients?

Dr Skerritt: The approach is, of course, that for registered medicines, they can apply through the Pharmaceutical Benefits Advisory Committee for reimbursement.

Senator DI NATALE: Yes, but this isn't registered.

Dr Skerritt: There's no government scheme at the Commonwealth level for funding or reimbursement of medicinal cannabis products.

Senator DI NATALE: Is there any work being done in this area to bring the cost down?

Dr Skerritt: Not that I'm aware of.

Senator DI NATALE: You're not doing anything in this space?

Dr Skerritt: No, it's beyond the role of the regulator. We'd also add that the first three commercial crops have been harvested from Australian-grown cannabis. I can't disclose their locations, as you'd understand. We would hope that in the coming months there would be Australian-manufactured product. And, with the announcement that those companies can also

export, providing they service all Australian patient requirements, we'd hope that the size of that market and the local manufacture would bring prices down. In fact, just yesterday, we met with a particular company that currently isn't providing product in Australia but was of a view that they could provide product at about a quarter of the price of their competitors. And we said: 'Please submit import permit applications. Pricing is up to you, but you'd certainly get a fair bit of market share if you can do that.'

Senator DI NATALE: It's still true that in some states GPs can't prescribe medicinal cannabis, is that correct?

Dr Skerritt: There are some states that have an absolute—it varies almost day to day, state to state.

Senator DI NATALE: Day to day?

Dr Skerritt: No. What I'm saying is that the requirements are being relaxed at the state level, and that is also—

Senator DI NATALE: But right now, if you're a GP in, I think, New South Wales and Queensland, you can't prescribe it.

Dr Skerritt: It varies. For some pathways, GPs can, in those states, and, as we go from day to day, that's being relaxed. It's a dynamic thing because, remember, what we're aiming for is a single process.

Senator DI NATALE: Yes.

Dr Skerritt: And so it will be irrelevant whether in 2017 or 2016 a GP could or couldn't, or in early 2018.

Senator DI NATALE: But it's relevant right now.

Dr Skerritt: But we're hoping it won't be relevant much longer.

Senator DI NATALE: I know; we're all hoping. But right now, if you're in Queensland or New South Wales and you go and see a GP, you can't get it. You have to go and get it from a specialist. Is that correct?

Dr Skerritt: I believe that's the case as of today in Queensland. I know that there is some work being done—and again, this is still only work at officials level—on whether that system can be changed.

Senator DI NATALE: My final question is about the Medicinal Cannabis Legislation Amendment (Securing Patient Access) Bill, which was basically the change to Special Access Scheme Category A. That passed the Senate last year. This question may not be for you, Dr Skerritt, but does the government have any plan to remove the barrier through Special Access Scheme Category A?

Dr Skerritt: That bill is still before the parliament and, as an official, I don't comment on bills before parliament.

Senator DI NATALE: Senator McKenzie?

Senator McKenzie: Sorry, Senator?

Senator DI NATALE: At the moment, you cannot access medicinal cannabis through the Special Access Scheme Category A. A bill passed the Senate. It hasn't been brought to the

lower house yet. Does the government have any plans to make cannabis available through Special Access Scheme Category A?

Senator McKenzie: This is an area for Minister Hunt. I'll take that on notice.

Senator DI NATALE: Okay. Thank you.

Senator LEYONHJELM: Senator Di Natale went down a similar pathway to some of my questions, but there is still the issue of what quantities of medicinal cannabis can be imported—what will be allowed in—and what's here. Even assuming the successful navigation of the permit approval system—prescription and so forth, that you were discussing with Senator Di Natale—what's available in Australia?

Dr Skerritt: First of all, there's no limit on the quantity. That's written into regulation. It's considered on a case-by-case basis. Clearly, if someone wanted to theoretically import material for a million patients, you would start to raise concerns about diversion, in the same way if it were an amphetamine and those quantities were imported. I can tell you that the quantities that have been imported can do several hundreds of patients at a time. There are a couple of hundred companies that have applied for licences to import. There are at least a couple of dozen that have products in the country. Again, that list changes by the week, and it's published. Some companies say, 'We don't want to publish it,' but the companies that have consented to publish the information on what they have in the country is on the Office of Drug Control's website. A doctor can go to www.odc.gov.au and look down a list of products with various cannabidiol and THC concentrations and ratios and determine what they would like to prescribe for their patient.

Senator LEYONHJELM: The suppliers of these products can't make claims for them, because they're not registered. Are they bringing the differences to the attention of those who might prescribe them in some way? I understand there's quite a spectrum of applications.

Dr Skerritt: You're right in that an unapproved prescription medicine at this point in time cannot be advertised to physicians. However, we talked earlier with Senator Di Natale about the number of education programs. In these education programs, a strong emphasis is that with these high THC products there's more evidence for them in these conditions; ones that have both THC and cannabidiol are more suited for these conditions; and the ones that are high in cannabidiol might be more suited, for example, for paediatric epilepsy. So, it's not saying brand X or brand Y, but it's giving the prescribers information about what sorts of products to go for when they write a prescription.

Senator LEYONHJELM: Are products in each of those categories, say, high THC, high cannabidiol or some sort of mixture being imported?

Dr Skerritt: There's quite a range being imported. There's also quite a range of what we call 'dose forms'. There's everything from oils right through to certified raw product.

[15:47]

CHAIR: We are moving from program 5.1 to 5.2: Health Protection and Emergency Response. Senator McCarthy, you have the call.

Senator McCARTHY: I'm going to go to PFAS, Minister. I have questions for your staff who handle PFAS in the Katherine region.

Senator McKenzie: We're armed with information, Senator.

CHAIR: Senator McCarthy, just before you start on PFAS, I was literally just a few minutes ago handed this document. I just thought for the committee's information it might be worth noting. It's dated today and states: 'A new parliamentary inquiry will examine the Commonwealth government's management of PFAS contamination in and around defence bases. The inquiry will be conducted by the PFAS subcommittee of parliament's Joint Standing Committee on Foreign Affairs, Defence and Trade. The subcommittee is chaired by Mr Andrew Laming MP. Mr Laming said the inquiry will examine the progress of the Commonwealth government's response to and management of PFAS contamination. It will build on previous parliamentary inquiries into this issue in light of recent developments, including the establishment of the whole-of-government PFAS task force, and report by the Expert Health Panel for PFAS.' It goes on, but I'll get the secretariat to make some copies and circulate it.

Senator WATT: Well done, Senator McCarthy.

Senator McCARTHY: Thank you. Thank you, Chair. I just put on the record that I'm the deputy chair of that committee.

Senator WATT: Hear, hear!

Senator DODSON: I didn't know that news.

Senator McCARTHY: If I could take you, Ms Appleyard, to the announcement in December of the community support package for Katherine. I want to go through a couple of things with you on that. Have the mental health and counselling support services arrived in Katherine?

Ms Appleyard: Yes, the mental health and counselling services commenced on 28 May. I guess that would have been Tuesday.

Senator McCARTHY: Where did they commence in Katherine?

Ms Appleyard: I would have to take that on notice for you. I know that providers have been commissioned to provide those services by the private health networks.

Senator McCARTHY: Is there a mental health professional or are there mental health professionals in Katherine, which was promised as a part of that support package?

Ms Appleyard: That is my understanding, but I'll confirm that precisely for you.

Senator McCARTHY: So why has it taken until the end of May?

Ms Appleyard: The department funded the primary health network in about February to commission those services, and this is the time that it's taken the primary health network to do the work that it has had to do to identify the providers. One of the things that the PHN has been doing is making sure that additional capacity is brought into Katherine so that we're not drawing down but adding to the fairly limited health service providers that exist in what is a small community and not creating workforce strain.

Senator McCARTHY: Thank you. I'm going to take you to questions about health advice. What advice has Health provided to doctors about levels of PFOS, PFOA and PFHxS in blood tested as part of the Voluntary Blood Test Program?

Dr Hobbs: On two occasions on visits to Katherine, I've met with the local GPs and also visited their practices—Gorge Health and Wurli-Wurlinjang—to give them information about per- and polyfluoroalkyl substances generally and about the Voluntary Blood Testing

Program. This was to not only give them a general overview but also to share with them some support literature that the department had generated and used in the communities of Williamtown and Oakey. With particular reference to the Voluntary Blood Testing Program, this was a resource about the conversation that GPs should have with their patients prior to the blood tests so that patients gave informed consent and that they understood the limitations of a blood test. In particular, that they understand that there is no normal level of these chemicals because we've all been exposed at some point during our lifetime since they've had a wide variety of domestic uses as well as its very important use as firefighting foam. Any particular level of PFAS in the blood does not mean that you're more likely than anyone else to develop a health condition, and that has recently been confirmed by the Expert Health Panel.

Senator McCARTHY: How many GPs have been briefed in Wurli and Gorge?

Dr Hobbs: I would have to take that on notice. I don't have those numbers in front of me. But, as I said, I've done that on two occasions and visited those two practices on my last visit there in March.

Senator McCARTHY: What process is set up for doctors to follow if high levels of PFAS are detected in the blood tests?

Dr Hobbs: We have a resource called the post-blood test consultation. There is some advice and support to GPs about how to have that conversation, noting that if a patient does come back with a blood level that is elevated against the pooled background level—I'll come to that in a moment—then the GP should put that in context. We have referred them to a study, which was in the literature in 2014, that was based on pooled Australian levels of PFOS and PFOA, with an age distribution. If someone came back with an elevated level of, say, PFOS, which is the most likely, given our experience across these three sites, then the GP could say with confidence that that level is less than the 95th percentile of the Australian pooled data or above it. If it comes back above it, it just means that, at that particular time, that person's blood level is that level. It doesn't give any indication of how that person was exposed or when they were exposed. I just gives a level. As I said, part of that conversation is to reassure patients that, even in very highly exposed populations in the literature in the United States, where a lot of the manufacture of this products was undertaken, people with blood levels in excess of 1,000 micrograms per litre still have no health problems.

Senator McCARTHY: I will get there, but there have been a number of media reports in the *Katherine Times*, as I'm sure you're aware—

Dr Hobbs: I'm aware of those, yes.

Senator McCARTHY: where a doctor has reported extremely high levels of PFHXS in the blood levels of people tested. Have the procedures and advice been provided to that particular doctor?

Dr Hobbs: I've actually spoken with that doctor on a couple of occasions. I briefed him when I was in Katherine on two occasions and also visited his practice.

Senator McCARTHY: Is the doctor following the procedures and advice that you have provided?

Dr Hobbs: There are a couple of issues. I don't know exactly what advice he's giving to his patients, because I'm not part of that conversation, obviously, and obviously those consultations—

Senator McCARTHY: It's just that you said you spoke to him, so—

Dr Hobbs: I spoke to him before and afterwards. He has raised concern with me that patients have elevated blood levels. My advice back to him is: 'Well, that is not necessarily surprising given that there is known contamination on the RAAF Tindale base.' We know the aquafer has been contaminated by these chemicals and that the people who were drinking bore water, for instance, may well have levels elevated compared to people who weren't exposed to that water. It would not be surprising that some people would have elevations above the general population.

Senator McCARTHY: You spoke prior to these reports. Has anyone spoken to the doctor since the reports in the local media?

Dr Hobbs: I have, yes.

Senator McCARTHY: And what's been the response?

Dr Hobbs: He has expressed concern to me that some people have elevated blood levels and I have said to him that the evidence we have, most recently from the Expert Health Panel, is that there is no consistent evidence of harm due to exposure to these chemicals.

Senator McCARTHY: But could he be right in terms of some of the examples that he's provided in the public space on this?

Dr Hobbs: I can only comment on what I've read in the press about some of those levels. He has not shared with me the levels about particular patients, nor should he, and that would not be part of my role, obviously. Again, it is not surprising that some people in that community would have elevated blood levels. I would refer to the Expert Health Panel report just recently released, earlier this month.

Senator McCARTHY: Dr Hobbs, that doctor claims he's not received information about PFHXS. What might be best here is: has there been any written documentation that you care to table to Senate estimates to show any conversations or correspondence where he has been made aware of what you've told us?

Dr Hobbs: I have two comments. I'll defer to my colleague Ms Appleyard as to whether she's happy to table emails. There is certainly an email trail. In fact, there's been a lot of correspondence with that particular doctor. He's quite right in saying that there is more evidence in the public domain about PFOS and PFOA than perfluorohexane sulfonate, but, nonetheless, there is information. Indeed, the Expert Health Panel report does refer to PFHXS, or perfluorohexane sulfonate, and its general class as a PFAS agent. But, again, the evidence in that report—as I said, just made public earlier this month—does not point to any particular and consistent evidence of harm to the health of humans from exposure.

Senator McCARTHY: For the interest of the committee, I think it's important to see that documentation, given that there is a public conversation going on which is causing deep distress and alarm to families in Katherine. I think it's important for this Senate committee to actually see what correspondence has taken place in relation to the advice given and we can take it further from there. Would you be able to take that on notice?

Ms Appleyard: I'll take that one on notice.

Dr Hobbs: Just for the senator's information, I am going back to Katherine in June for another community consultation, together with colleagues from Defence. We are also taking

with us the chair of the Expert Health Panel report, Professor Nick Buckley, with the express desire to better inform the GPs and other health professionals and of course the community. Last time we were in Katherine, we also met with the local mayor and the local council and briefed them. I would assume that we would do that again as part of our ongoing support to the local community and, indeed, the GPs looking after that community.

Senator McCARTHY: One last question—

Prof. Murphy: I will just add something, I think that we are collectively concerned about some of the statements that this particular doctor has made. We think it's creating unnecessary community concern and we're not convinced that—

Senator McCARTHY: It's causing a lot of distress.

Prof. Murphy: We're not convinced that they're based on evidence that's been provided. I think Dr Hobbs has been to many of these community consultations and most GPs have responded extremely well to the reassurance and education he's given, and we hope that this further visit will achieve that. We feel that there has been quite unnecessary community concern raised recently by the comments of this doctor.

Senator McCARTHY: If he is right in those concerns, then that is even more alarming, and unless there's been a clear case of ruling that out this committee needs to see the documentation. A final question, Ms Appleyard, in terms of counselling, is there counselling available now?

Ms Appleyard: I've been advised that from 28 May, so that's Monday, counselling services are available in the Katherine area. And there is support provided by group called support now, that's online and telephone counselling services, and they've been available all the way through. The pre- and post-blood test counselling, which is a slightly different thing, is available from general practitioners, including in the AMS in the region.

Dr Hobbs: For the record, the PHN did also contact both of the general practitioners to provide two specific counselling sessions, in addition to those around the voluntary blood testing, in the recognition that access to psychological services in Katherine was problematic. As an additional investment in the community, which has not been taken forward in Williamtown or Oakey, both of those practices have the ability for the GP to offer counselling and support as well as just the conversation around the blood testing.

Senator McCARTHY: Thank you, Dr Hobbs.

Senator DODSON: I raised some questions yesterday under 2.3 about Indigenous employment. I'm not intending to go back into that space. I want to deal with the syphilis matters and I want to deal with HTLV-I. That is the main bulk of my interest. In relation to employment—you may want to take it on notice—I want to know what designations those 125 you mentioned, who were employed within the department, sit at in terms of deputy secretaries, first assistant secretaries or directors? What are the classifications that those positions correlate to? Is there a First Nations person in charge of the Indigenous health branch or section of the department?

Ms Beauchamp: I'll take the first question in terms of the breakdown of what levels the 125 people are at. In terms of the heads of both divisions and branches, I'll hand over to Ms Edwards.

Ms Edwards: There are four SES staff who work in the Indigenous health division—three assistant secretaries and one first assistant secretary. Of the four, there is one Indigenous officer and two permanent non-Indigenous officers. The first assistant secretary position is in the course of being recruited. The new occupant will commence, I think, next week and he is a non-Indigenous officer. That's 25 per cent of the four SES officers in that division.

Senator DODSON: Thank you. I will go to the syphilis matters. Can the department confirm that, since February, with the percentage of cases reported for the 15-29-year-olds there has been a slight increase in Western Australia and South Australia?

Ms Appleyard: I don't have a breakdown by age group in front of me here but I do have numbers for up until this point in 2018, if that would help you.

Senator DODSON: That'd help, thank you.

Ms Appleyard: This would be 31 March, year to date. I'll tell you the four outbreak regions. Starting off with Kimberley, which I know you're interested in, there are seven cases that have been reported. This is new cases.

Senator WATT: That's all age groups?

Ms Appleyard: All age groups, that's correct. There are four in South Australia, 58 in the Northern Territory and 66 in north Queensland.

Senator DODSON: There are 66 in north Queensland?

Ms Appleyard: That's right.

Senator DODSON: Is there any way to get them broken down into those age groups? Take it on notice.

Ms Appleyard: Quite possibly. I can take that on notice, yes.

Senator DODSON: Thank you very much. Can you confirm also that between 1 and 31 March 2018 there have been 40 new cases of syphilis across the Northern Territory in Aboriginal and Torres Strait Islander communities? That seems to conflict with the figures you just gave me of 58, I think.

Ms Appleyard: Yes. I would definitely have to take that one on notice. For the month of March, you're asking?

Senator DODSON: Yes.

Senator WATT: Those figures you gave us before, were they for all residents of those regions?

Ms Appleyard: For the outbreak regions, yes, which are clearly defined. For the four outbreak regions, they're all cases.

Senator WATT: That's not restricted to Aboriginal and Torres Strait Islander people or communities?

Ms Appleyard: I'm just having a look at the case definition. I think the case definition does say that Aboriginal and Torres Strait Islander is part of the case definition. So it's an Aboriginal and Torres Strait Islander person residing in that region.

Prof. Murphy: The numbers in non-Indigenous people would be very low.

Senator DODSON: At the last estimates, I think, at the cross-portfolio session, there'd been six fatalities from congenital syphilis in Queensland. Can you give me an update on not only Queensland but the other—

Prof. Murphy: We are not aware of any additional deaths, and they've only been in the Queensland area. There have been, I think, 11 or 12 cases of congenital syphilis —

Ms Appleyard: I think 13.

Prof. Murphy: or 13 now, but only six of those have been fatal. We're not aware of new cases of congenital syphilis. The issue with congenital syphilis relates to antenatal screening. In the Northern Territory they conduct a very thorough screening two or three times in pregnancy. Queensland have really upped their game in antenatal screening. The challenge is people are screened and may be negative early in pregnancy and they become infected during pregnancy, so you need to screen on multiple cases.

Senator DODSON: The announcement of the $8.8 million was made. Can you provide a breakdown of the spending allocations by activities and jurisdictions? You might want to take that on notice.

Prof. Murphy: I think the spending we'd have to take on notice. We can certainly describe what's happening. We're just about to start, right now, the initial tests and enhanced response in Townsville, Cairns and Darwin associated with the art shows. We're currently liaising with jurisdictions, NACCHOs and Aboriginal Community Controlled Health Services to get the next phase of sites, which will most likely include the Kimberley region, Katherine, East Arnhem Land and Mount Isa and its surrounding communities, with a commencement in the first quarter of the next financial year. We're also investigating sites in South Australia. So we're geared up to get going with those first three sites, as we speak. We've got all the equipment and we're doing the training.

Senator DODSON: Can you confirm or put me straight as to whether there are any further funding allocations in the 2018-19 budget towards the control of the outbreak?

Ms Appleyard: No further funds. But what I will say is that the implementation plan that will be associated with the new Aboriginal and Torres Strait Islander BBV and STI strategy is yet to be finalised, and any funding commitment associated with that implementation plan is something that is yet to be determined. As for the 2018-19 budget, the answer to that is no, no specific funding.

Senator DODSON: So I can confirm that there's nothing in the 2018-19 budget and there's nothing in the 2019-20 budget and there's nothing in the 2020-21—

Prof. Murphy: At this stage, no. But we have adequate money from that $8.8 million to do all the response that we're planning at the moment. We have sufficient funds; we're going as quickly as possible. We're not limited by funds in developing our response at the moment. We have sufficient funds to continue the response as planned over the foreseeable future and we have assurances from government that financial barriers should not be a barrier to stopping this enhanced response.

Ms Edwards: Just to be clear, the $8.8 million is over a three-year period, so you appreciate—so it's partly in this current financial year, 2017-18, and then in the two following.

Senator DODSON: But there are no further funds to the $8.8 million.

Ms Edwards: There were no additional funds specifically for syphilis in the budget.

Senator DODSON: Yes, I understand that. What I was asking was, are there additional funds beyond the $8.8 million in the outer years.

Ms Edwards: That's adequate for the syphilis outbreak.

Prof. Murphy: I think what Ms Edwards is saying is that this money is allocated over those three years. So we have sufficient funds to do what we're doing at the moment. If we run into financial barriers, government has made very strong commitments to us to come back and discuss it. We have sufficient money to do the response that we're planning at the moment.

Senator DODSON: Can you tell me whether the Commonwealth's allocations that are being made in the various regions are being matched in any way by the states and territories? Is what you're outlaying being matched by states and territories?

Prof. Murphy: I don't know whether Mr Carlile might want to add anything on that.

Mr Carlile: Part of that funding, that $8.8 million, is specifically the Commonwealth contribution. We're delivering that through Aboriginal community controlled health services. As part of our discussions and deliberations, we're engaging with states and territories as we go around to negotiate with Aboriginal community controlled health services to make sure that that is an integrated response with state health services. It's up to the states, of course, to decide what they will contribute or what they will add, but this is all part of AHMAC's agreed action plan. All the states and territories have agreed to the enhanced action plan. They've agreed that there needs to be some enhanced response to this outbreak, so the Commonwealth for its part has put forward the funds. We've decided to deliver those through the Aboriginal community controlled health sector, and we're negotiating with states as we go around on what further contributions and integration of services can occur.

Prof. Murphy: Queensland have already announced, in their last year's budget, a commitment of additional funds to enhance their response. They committed, I think, an additional 16 million, so they have definitely put in extra state based resources. We're still working with the Territory government on additional contributions; they obviously feel that they have less capacity to make additional contributions. Our discussion with our state and territory colleagues has been that we're happy to front load the enhanced response to really try and get on top of this condition, but they have a primary responsibility for sexual health, and they're going to have to be clear that they will have a significant role in the sustainability of this response. We're very clear that we don't just want to come in and break the back of this problem and then move away. This solution has to be sustainable. We have to not control it and then, several years later, have it come back again. We have to make sure—

Senator DODSON: I understand that and I appreciate you saying it. I notice you didn't mention Western Australia or South Australia in your answer.

Prof. Murphy: We are having discussions with those states. I'm not aware of any specific contribution—

Mr Carlile: We'll actually be meeting with South Australia in the next couple of weeks. We'll meet with the South Australian government and the Western Australian government, as well as ACCHS in those areas.

Senator DODSON: That's about the funding commitments?

Mr Carlile: To talk about the integration, how their services can interact—often it's the case where the Aboriginal community controlled health services aren't delivering, aren't working, in isolation, that there are joint services with state governments, particularly in the Kimberley area, as you would know. We're advising the state governments on what we're doing so they can finesse their own contribution or what work they need to do.

Senator DODSON: I don't want to be asking the Minister for Indigenous Affairs what contribution the state is going to make to this. I'm just trying to find out whether the state of Western Australia and the state of South Australia are making a comparable contribution to this, or—

Prof. Murphy: Not at this stage, but we're very confident, with our discussions—if we don't get a good response to these local discussions at officer level, we will escalate it. They have very much a responsibility as well, but there's no tangible financial contribution that we've seen.

Senator DODSON: At this point?

Mr Carlile: Yes, at this point.

Senator DODSON: Okay. Thank you for that. Back in February, again I think you—

CHAIR: Excuse me, Senator Dodson: how long do you think you have to go, because we are supposed to have a break now.

Senator DODSON: A couple of days, Mr Chairman! If you want to break, but I have several other questions.

Prof. Murphy: We're in the hands of the senators.

Senator DODSON: You certainly are, but we don't want to inconvenience you.

CHAIR: No, no. It's just if you've still got a few—

Senator DODSON: I've got about five questions on syphilis—

CHAIR: And then other questions—

Senator DODSON: and then, as I've mentioned, I've got some on HTLV-1.

CHAIR: In that case, I think we will break now.

Senator WATT: Could I just add one quick question that's come in while we've been talking. Earlier you said that you'd take on notice Senator Dodson's question seeking confirmation of the number of new syphilis cases across northern Australia in Aboriginal and Torres Strait Islander communities for the month of March—

Ms Appleyard: I actually have that information, Senator.

Senator WATT: You do?

Ms Appleyard: Yes, I do. I would be happy to provide it. This is from an epidemiological report for 1 to 31 March. Do you want it for the four outbreak regions, Senator?

Senator WATT: Yes, if you've got it.

Ms Appleyard: The number of cases for North Queensland is 19. In the Northern Territory it's 13. In the Kimberly region it's six. In South Australia the number is two.

Senator WATT: So, all up it's 40?

Ms Appleyard: Your maths is probably a bit better than mine, but, yes.

Senator WATT: Do you have those numbers for the month of April?

Ms Appleyard: I don't believe so, no.

Senator WATT: Could you take that on notice and see in the break whether someone might have them?

Ms Appleyard: Yes, we certainly can.

CHAIR: We will suspend until 4.35. When we come back Senator Dodson can finish up this line of questioning, but Senator Rhiannon has been waiting very patiently—

Senator SIEWERT: So has Senator Siewert—

CHAIR: So has Senator Siewert.

Senator SIEWERT: for quite a period of time.

Senator DODSON: I don't think anyone's got that distinction around here, Mr Chairman.

CHAIR: We have a few people lined up, so we'll keep moving through this as quickly as we can. Thank you. We are suspended.

Proceedings suspended from 16:17 to 16:34

CHAIR: We will recommence. We are at program 5.2.

Senator DODSON: In February, during the cross-portfolio matters, it was announced that the rapid point-of-care tests would be initiated to reduce these outbreaks. How many of these rapid tests have been undertaken since February?

Prof. Murphy: I think what we said before is that we're just about to start now. We have been gearing up to that process and at those three initial sites we have been having to get staff on board and train up staff. They're just about to start now. So we have had to get all the equipment, all the point-of-care tests and all the antibiotics and train everybody up and they're starting now.

Senator DODSON: Do you have sufficient point—

Prof. Murphy: We have sufficient to go straight through.

Senator DODSON: Okay, thank you. How much of the $8.8 million is going to Aboriginal community controlled health services?

Prof. Murphy: We would have to take that on notice, I think, unless Mr Carlile can provide any early—

Mr Carlile: Certainly. The majority of the funding will be going to Aboriginal community controlled health services. The funds that aren't are really to do with the point-of-care test acquisition, some community material engagement, material which will be used by the Aboriginal community controlled health services, and also the training package to support the rollout of the point-of-care test. But, apart from that, the bulk of the funding is actually going to the ACCHS.

Senator DODSON: This is probably connected to your answer. How much of the funds are going to SAHMRI to conduct or develop community awareness and education?

Prof. Murphy: We've previously provided significant funding to SAHMRI. That was provided in a previous measure. Their program has been up and running. I'm not sure whether we're giving them any additional to expand it.

Mr Carlile: We're providing some additional funding—we have just finalised the negotiations on that—as an extension to their existing material to extend that and roll it out to the different areas.

Senator DODSON: So you extended funding?

Prof. Murphy: The material is already prepared. What we're trying to do is get greater coverage of the very good social media and other communication packages that they have developed. So they need more money to buy more access in the media.

Senator DODSON: Can you tell me what that amount is?

Mr Carlile: I'd rather not because they haven't finalised—

Senator DODSON: They haven't completed—

Mr Carlile: negotiations.

Senator WATT: Does that mean there's nothing actually in the forward estimates?

Prof. Murphy: The $8.8 million is in the forward estimates, and that's the—

Senator WATT: So there's $8.8 million overall, some of which is going to community controlled health services and some of which is going to SAHMRI for an education campaign?

Prof. Murphy: Yes, to extend the existing education campaign, not to create an education campaign.

Senator WATT: But you don't know how much has specifically been allocated to the education campaign?

Prof. Murphy: We're still negotiating, as Mr Carlile said, so we won't know the final figure until that's finalised.

Ms Edwards: Just to be clear about the $8.8 million, it's $3 million in this current financial year, $3 million in 2018-19 and $2.8 million in 2019-20.

Senator WATT: Thanks.

Senator DODSON: On the reporting across the multijurisdictional syphilis outbreak area, is there a report for April?

Ms Appleyard: There isn't a report for April. This goes to Senator Watt's question as well, so I will clarify. Because we coordinate the epidemiological information from states and territories, that takes us a little while, so the May report that we're looking at is March data, and the April data will not be available probably for another few weeks. But, as soon as that data is available, that will be in next month's report. It will be for the month of April.

Senator DODSON: Covering the April period?

Ms Appleyard: That's correct, Senator. That's right.

Senator DODSON: What allocation has been made available to the functions of the Multijurisdictional Syphilis Outbreak Working Group? Have there been funds allocated to them?

Ms Appleyard: They are an existing working group that sit under CDNA, so they are already funded, I guess you could say, because they exist to do this work. Their main work is really to do with data and surveillance and the epidemiology interpreting that.

Senator DODSON: It's part of their normal course of activities?

Ms Appleyard: That's correct, Senator, yes.

Senator DODSON: I just want to be put straight. Have you got an outline of your long-term strategy? I've heard what the Chief Medical Officer's had to say about state responsibilities, but is there a long-term strategy to manage STIs and BBVs?

Prof. Murphy: There is a long-term strategy that we created when we took this to AHMAC. The detail of that strategy is much finer in the short term. We still have to work through. The key points of the long-term strategy are definitely in the overall plan, but we have to, obviously, work through with the states and territories the detail of how the medium- and long-term sustainability path will go. We have very good, detailed operational plans for the short term. We have the bones of what we need to do in the medium and long term, but we haven't got all the fine details of that at this stage.

Senator DODSON: Is there any time line around when you might conclude that?

Prof. Murphy: It's a progressive process. This plan will be refined over time, but I think that, by the end of this year, we'd want to have a pretty good vision of what the sustainability path will be, because we've been very clear at the outset that we do not want this to be just an acute reaction and a response; we want this to be a long-term solution.

Senator DODSON: I've heard that and I appreciate your sentiment. But, when you say 'this year', do you mean this financial year or this calendar year?

Prof. Murphy: I'd say the end of this calendar year.

Ms Appleyard: There's another meeting of the governance group that oversights this, Senator, towards the end of the year. The action plan as well is on the internet, and it really does talk in terms of short-, medium- and long-term milestones. But, as Professor Murphy has said, dates haven't been put against those, because we really want to keep it flexible. As we learn more in response to the outbreak, we'll be able to determine how best the next steps would look.

Senator DODSON: With the escalation of some of those figures, maybe it's important to ramp up some of this. Those are probably my questions to that point.

Senator RHIANNON: I'd like to go back to your work on the PFAS contamination.

CHAIR: We're going back to PFAS? That's fine. Can I interrupt there for a second. We have got confirmation that the TGA are no longer required, so they are released, along with those in program 5.1 who are not needed for a later outcome. Sorry, Senator Rhiannon, I just wanted to let people go home when they can.

Senator RHIANNON: Yes, that is understandable. I want to continue with some questions about PFAS contamination. Does the department have a policy when it comes to applying the precautionary principle?

Dr Hobbs: Yes. Thank you for the question, Senator. The approach that we are taking is a very precautionary population health approach, and it really does reflect the advice of the expert health panel, which basically stated in their summary that, even in the absence of any consistent ill-health effect in humans from exposure to these chemicals, because they persist in the environment and can bioaccumulate, you do need to take a precautionary approach, and that approach is certainly to mitigate ongoing exposure of the population. The second approach, of course, is—in recognition of the concern, worry and in some cases mental health distress that this can cause residents in those investigation areas—to provide ongoing support through the approaches that we talked about before, so the online support through Support Now, face-to-face psychological support and obviously working with local general practices or Aboriginal medical services.

Senator RHIANNON: I got down notes about mental health issues, but what was the first aspect of how you're responding in terms of the precautionary principle, please?

Dr Hobbs: The precautionary approach is that, because these chemicals persist in the environment and can bioaccumulate, even in the absence of any consistent evidence of human harm due to exposure, the approach should be to mitigate or reduce ongoing exposure to the chemicals over time.

Senator RHIANNON: Thank you very much. Going on to the report of the Expert Health Panel for PFAS, I just want to read out this quote because I think it is probably what you're referring to in part:

… the panel noted that even though the evidence for PFAS exposure and links to health effects is **very weak and inconsistent**, important health effects for individuals exposed to PFAS cannot be ruled out based on the current evidence.

I imagine that's the summary of the report that then gives a frame for your approach with the precautionary principle. Is that fair to say?

Dr Hobbs: Yes, that's correct, Senator.

Senator RHIANNON: You've outlined the mitigation and then also handling people's wellbeing and their mental health. Wouldn't it be wise, in the context of a precautionary principle approach of making a recommendation to other government departments dealing with PFAS contamination, for the residents actually to be bought out so they can leave their properties?

Dr Hobbs: That is a matter for the government. It's certainly not a matter for Health.

Senator RHIANNON: But how do you distinguish what's a matter for government and what's a matter for the health department? I've been interacting with the Department of Defence over this for many years, and I note that they will make decisions about supplying people with clean water and giving them advice about what they can eat and can't eat, but, when you get to aspects of this issue that involve large amounts of money, then it becomes a government decision.

It was a very impressive answer that you gave with regard to the precautionary principle. Particularly, it was really welcome to hear how you set out the issues to deal with the worry that many people have, the mental health issues, and the support that you're giving. Many of those mental health problems are arising because people are now not certain of their future. They literally don't know what to eat. In many cases they've given up a hope of staying in

their place and feel that they need to move now, but their place is worthless. Nobody will buy it. They've also got no money for their future, because many people's assets are tied up in their family home. So isn't the issue of compensation or the issue of buyouts part of a mental health approach?

Dr Hobbs: The approach from a Department of Health point of view is, first of all, to look at the evidence, to mitigate ongoing exposure and to understand that each community has its own special requirements or specific details. That's where the human health risk assessment comes in—that very, very extensive piece of work undertaken by experts to understand, in that specific investigation area, the routes of exposure. Most of that is through water, but there are some exposure risks through locally produced food, of course. There is mitigation of that ongoing exposure through provision of safe water. That's been through either bottled water in the short term or tank water or indeed a connection to the reticulated water through the local council. There is provision of mental health services, of course—noting that there is no treatment for reducing levels of these chemicals. They do reduce slowly over time.

When it comes to broader considerations about compensation or the like, that certainly is not a matter for Health; that is a matter for the task force and for the whole of government. That is certainly not from the Department of Health, Senator.

Senator RHIANNON: I will just explore that a little bit further. You've again spoken about water and produce. I imagine that those decisions are decisions that your department's making and that you wouldn't be giving the answer, 'Well, that's a matter of government.' Is that fair?

Dr Hobbs: Clearly, the Department of Health has worked closely with colleagues from the Department of Defence, the Department of the Environment and Energy and the Department of Agriculture and Water Resources in having a joined-up approach, because not all the levers and approaches to mitigate ongoing exposure sit with the Department of Health. Our primary role, of course, is to bring evidence to the table around exposure to these chemicals ongoing, and then clearly we look to new evidence as it might come forward, but clearly other departments across government have an important role here as well. We work closely with them, and that has happened through the interdepartmental structure. Maybe my colleagues can speak to that.

Prof. Murphy: I think, Senator, Dr Hobbs made it pretty clear that our remit in the Department of Health is to look at the potential health impacts of exposure to PFAS and to do what we can do mitigate those health effects. It's not our remit to look at the broader issue of compensation for people who feel that they may well have suffered financial hardship. That's a matter for other departments of government and government itself. It's not a matter for the Department of Health.

Senator RHIANNON: Let's take the word 'compensation' out of it. Going back to the answer to the original question about the precautionary principle: the second aspect was that detailed answer about the mental health aspects of it and the recognition that supports need to be given and how you're giving support. If part of the consequences of this contamination is that people's remaining in their home, remaining on their land, is causing the mental health aspects, isn't part of the precautionary principle recommending that something be done about that?

Prof. Murphy: I think that the role of the health department in that particular regard would be to reassure them about the fact that there really isn't a risk to their health, on current data, but the precautionary principle is such that they should make sure that they reduce exposure, and to try to provide counselling to support their mental health issues. But, broader than that, to deal with their life circumstances, as with anyone with mental health concerns, is probably not the broader remit of the Department of Health.

Senator RHIANNON: But isn't the definition of 'precautionary principle' not just about reducing the exposure but actually about removing the exposure? There are some very interesting examples around health issues where the science may not be conclusive or isn't conclusive but there are certainly concerns, and then the precautionary principle, if it kicks in, is about people or the environment—about not using those chemicals because of the potential problems that can occur. It seems as though you're using a slightly different—

Prof. Murphy: No, I think we have been saying that our precautionary principle is to determine very safe levels in water and food and to recommend that all steps are taken to reduce exposure, with a huge margin of error, because, as we say, there is currently no evidence of adverse health impacts. That's very much in the remit of the Department of Health and its evidence base. More broadly, you could draw the analogy of people with mental health conditions because of their social circumstances and other situations. It's not our remit to address all of these issues. Our remit is to address the evidence of health issues and the response to those health issues. The other arguments are for broader government consideration.

Senator RHIANNON: But, again, it would appear that you have veered away from the accepted definition of 'precautionary principle', which I understand is used by policymakers to justify discretionary decisions in situations where there is a possibility of harm from making a certain decision when extensive scientific knowledge on the matter is lacking. Now, we know that there are a divergence of views around PFAS, but there is certainly a view—and it was identified in the quote that I shared with you from the Expert Health Panel for PFAS, where it says—that 'health effects for individuals exposed to PFAS cannot be ruled out based on the current evidence'. Therefore, I come back to the accepted definition of 'precautionary principle'. When extensive scientific knowledge on the matter is lacking or not decisive, one then avoids the harm by removing it, whereas your mitigation measures are still leaving people in a situation where they can be exposed.

Prof. Murphy: No; our mitigation measures are reducing exposure. That's why there is an alternative water supply in Katherine. That's why we have made recommendations. That's why we have measured the environmental exposure. We have made recommendations based on the best available health evidence to reduce exposure, exactly consistent with what the expert panel has recommended.

Senator RHIANNON: But you're leaving them in the situation where they still are exposed to it.

Dr Hobbs: If I may say, Senator, that's why the human health risk assessment is so important. As I said, that's a very, very extensive and intensive study of the environment in those investigation areas—the groundwater, surface soil and various foodstuffs produced locally. The roots of exposure for that population in that particular circumstance are very well understood, so you can put in place ways to mitigate ongoing exposure, and that is exactly

what happens. We know that the major root of exposure is through water. So providing alternative sources of water is the No. 1 priority. Giving advice about limiting locally-produced food the local jurisdictions—and obviously Food Standards Australia and New Zealand talked about trigger factors for that—is very much a site-specific approach informed by the evidence collected as part of that human health risk assessment. Then there is the ongoing reduction of exposure over time. I'm confident that, when those measures are put in place, the risk to people of ongoing exposure to these chemicals is mitigated to a very large extent.

Senator RHIANNON: I want to move on to some questions about how the panel is working and the interaction with Defence. What input did the Department of Defence have in the expert health panel for the PFAS report?

Prof. Murphy: There was no input at all. We were very careful to select people who were experts in the area of toxicology and pharmacology who had no engagement with Defence. In fact, we excluded some experts who had been consultants for Defence in the past. We did not consult Defence. This panel was appointed by the Minister for Health on the basis of their independence, including an international expert who had no knowledge of Australia at all, and the other Australian members were people who were completely devoid from any of the Defence responses. It was entirely independent. The minister was very clear about the need to have true independence to get community credibility.

Senator RHIANNON: I also want to ask about the National Health and Medical Research Council's four-year study. Is the entire $12.5 million to be allocated to the NHMRC and its targeted call for research?

Prof. Murphy: I believe so, Senator.

Ms Appleyard: Senator, I think that's correct. There may be a small amount of that, around $200,000, available to support the expert health panel. I would just have to clarify that for you, but I think that's correct.

Senator RHIANNON: That was my next question. Has some of it gone to the Department of Health's expert panel and the PFAS report?

Ms Appleyard: Yes. My understanding is that that's $200,000, but I will correct that for you on notice if that does not happen to be correct.

Senator RHIANNON: The NHMRC has stated:

> The Government will invest $12.5 million over four years to increase the body of evidence and understanding of potential human health effects of prolonged exposure to per- and poly-fluoroalkyl substances (PFAS).

That statement clearly covers a large territory. You've really got a wide range of investigation there. Could it be involved in increasing the body of evidence of understanding of potential human effects of exposure to PFAS? Have you thought of narrowing it down?

Dr Hobbs: One of the outcomes of the work of the expert health panel was to better inform that targeted call for research. The expert health panel have made several suggestions about how that research could be taken forward, including the need for longitudinal cohort studies and use of blood tests over time. There is a range of suggestions considered as part of that expert health panel report, and they have been provided to the NHMRC to help inform them as well.

Senator RHIANNON: So will it be the Department of Health or the NHMRC who will be responsible for designing the parameters for the research?

Dr Hobbs: It will be the NHMRC.

Senator RHIANNON: I actually meant the research grants. So they'll work on all that. When can we expect to see the details of the NHMRC's target?

Prof. Murphy: We'll have to take that on notice and consult with the NHMRC. I should point out that there is also a pre-existing significant research study being conducted by ANU on epidemiology of PFAS. This was funded previously by government some years ago. That's well advanced and that's being informed by the three investigation sites and the blood test program that's being done. They've done their own literature review and they're doing a significant study of the epidemiology of those areas. So that's already underway.

Senator RHIANNON: I wasn't aware of that, so thank you for that. Considering that, which sounds substantial, from a great university, was it judged we needed additional work, or is this in parallel to it?

Prof. Murphy: I think this will be additional research work. It may complement the work that the ANU has been doing—that's to be determined—but I think government is very keen to address the unanswered questions, as you said in the report, that there is still, given the accumulation of these substances, the potential that we can't be absolutely sure that there are no adverse human health effects and, therefore, more research is needed. Australia has a very strong research community in this area, and I think we want to get as much evidence as possible.

Senator RHIANNON: Can you also take on notice the time line for the grant applications?

Prof. Murphy: We can provide that.

Senator RHIANNON: Will the purpose of the research simply be observational? Will the studies be limited to a periodic measurement of health parameters and PFAS levels in the affected population?

Dr Hobbs: That's to be determined.

Senator RHIANNON: Geographically, considering this is in so many areas now, is that to be determined?

Dr Hobbs: Again, that will be determined.

Prof. Murphy: That's in contradistinction to the work taken forward by the National Centre for Epidemiology and Population Health at ANU, which is concentrating on the communities of Oakey, Williamtown and Katherine.

Senator RHIANNON: I also notice that the panel recommends involving representatives of the exposed occupational group and/or community in study advisory committees for future PFAS research. Will this recommendation be included in the department's request to the NHMRC for the targeted call for research?

Dr Hobbs: That advice has been given to the NHMRC as part of the panel's report, so they have that already. Again, going to the work of the ANU, they are conducting as part of their study protocol community consultations with focus groups in each of those three affected communities.

Senator RHIANNON: You mentioned the university study. There's also been a Department of the Environment and Energy study. I think they looked at remediation and contamination in the soil. Will you be pulling in all these other studies as well?

Ms Appleyard: That's a separate research process that's occurring as well.

Prof. Murphy: It might be helpful if we agree on notice to ask the NHMRC to provide you with a detailed report on their plans, because they're not here at the moment and it would be helpful if they responded in detail.

Senator RHIANNON: Okay, good. Thank you.

CHAIR: We'll go back to you, Senator Dodson, then we'll go to Senator Siewert.

Senator DODSON: As I mentioned, my questions now are in relation to HDV1. Can the department inform the committee approximately how many Australians are carrying this particular virus?

Prof. Murphy: At this stage, I don't think we know. I think that's one of the challenges. We do not have really adequate epidemiology. We know that this virus has been highly prevalent in a number of remote Indigenous communities for a long time. It's been studied on and off for many years. We know prevalence rates as high as about 40 per cent have been reported in some communities, but there has been no fulsome epidemiological study across all communities, so we can't really tell you at this stage how many people are carrying this virus. It's important to recognise that this virus is largely asymptomatic, so, unless you've had a blood test, you would not know that you've had it. People carry it without any symptoms or disease for very many years—often 20, 30, 40 years—and historically only about five to 10 per cent of people have ever developed clinical problems from it: an unusual type of leukaemia lymphoma and occasionally some spinal disease. There has been a suggestion from the work recently done by the Baker medical research institute in remote Aboriginal communities that there is an association with another condition called bronchiectasis, where you have abscesses in the lungs. We don't know if that's a proven association yet, and nor do we know the full extent of the epidemiology of this virus. One of the key first tasks that ministers have tasked us with doing is to really understand in great detail the prevalence of this disease so that we can work out just where it is, what the proportion of people who are carrying the virus is and what disease associations are seen in the Australian context.

Senator DODSON: So you are not in a position to give me a ratio or a rate response to Indigenous and non-Indigenous?

Prof. Murphy: We know that, in blood donors—we screen blood donors in Australia for the virus—it's in very low prevalence. It is less than one per cent. In fact, in Australia it's almost confined to Indigenous communities and particularly remote Indigenous communities. There's very little evidence of this virus in the non-Indigenous community. We do know that—certainly from the blood donor information.

Senator DODSON: What studies have been done into the extent of the virus?

Prof. Murphy: As I said before, there have been studies on and off over the years that have looked at prevalence in some communities. Some studies have looked at prevalence in people admitted to hospital; some have done community surveys. The data is patchy, but the evidence would suggest that, in some communities, up to 40 per cent of people have been

carrying the virus. As I said, hardly any of them know they have it, because it's largely asymptomatic.

Senator DODSON: And that's 40 per cent of the First Nations population?

Prof. Murphy: In those remote communities, yes. But that's only in a few communities. We haven't studied the whole Indigenous population.

Senator DODSON: It's a wonder; there have been a lot of studies on us. Anyway, I appreciate what you're saying. In the sites where there's been testing, what's been the prevalence of the virus? As you say, it is 40 per cent in some of those populations?

Prof. Murphy: Up to around 40 per cent is the statistic we've had. But some areas have been lower than that. We've only got patchy.

Senator DODSON: That's the median or the average?

Prof. Murphy: The highest readings have been around 40 per cent.

Senator DODSON: If an Australian wants to get tested, where do they go and how much would it cost?

Prof. Murphy: I think that, at the moment, the antibody tests have been done only really in a research context. I'm advised that one community of 100 people had an incidence of 45 per cent, so I'm corrected on that. That was just a small community. So, at the moment, the antibody test is not available generally as pathology tests. It's done in the research laboratory context. One of the things we'll be looking at very early on in this approach is how we can provide better access to tests to study the epidemiology. It probably wouldn't be through the Medicare system, because it's confined to a relatively small population. We'd probably look at providing it through maybe the state pathology laboratory. We have to work that through. The other tests that are probably relevant, as well as whether or not you're carrying the antibody, are tests for the viral load, which haven't really been developed in Australia yet, and they become particularly relevant.

Senator DODSON: If you lived in Central Australia, would you be able to get a test at the Alice Springs base hospital or the Tennant Creek Hospital or the AMSs in those places, or do you have to go somewhere outside or to Darwin to get the tests, and how long is it going to take?

Ms Appleyard: The antibody test is actually available on the MBS, so the serology, the blood test, can be taken, but the proviral load, as Professor Murphy has said, is only available currently in a research environment. But you can get a blood test—

Senator DODSON: All I want to know is whether you can get tested in Alice Springs or Tennant Creek or any of those places or whether you have to have the test out of the Northern Territory or up in Darwin.

Ms Appleyard: No, my understanding would be—and I can certainly confirm this on notice—that, if it's Medicare rebatable, then you should be able to get a blood test anywhere that offers that serology.

Prof. Murphy: That will just tell you about the antibody.

Senator DODSON: What's the cost of this?

Prof. Murphy: It's on the MBS—

Ms Appleyard: I heard Senator Scullion say something at the last estimates, but I can't say for sure.

Senator DODSON: I think he said about $600 or something.

Ms Edwards: Senator Scullion said $169, which he had derived from media reports. I wasn't aware of a price at the time, you might recall. So there's a reported cost of $169, but we're not in a position to really verify whether or not that's what you would be charged, although we could probably take on notice the value of the MBS item.

Senator DODSON: I'd imagine people in Central Australia, where this seems to be prevalent, are getting worried and wanting to know how they can have a test. If there are no symptoms, how would they get to know whether they've—

Prof. Murphy: Indeed, that's the challenge. That's why we want to do this epidemiological study and understand the true nature of the disease. There's probably not much value in people going off and getting random tests and not knowing what it signifies. That's why we want to do some more studies.

Senator DODSON: How much of the $6.1 million in funding that's been allocated to the Central Australian Academic Health Sciences Centre has been allocated to address this particular issue?

Ms Appleyard: I think the answer I gave at estimates last week is that that hasn't been determined yet. That will be a decision for that centre to determine. As you quite correctly point out, it's a component of the 6.1.

Senator DODSON: In terms of the research component and the clinical response—that is, testing and other things—is there a breakdown of that sort of figure or a response to that kind of division?

Ms Appleyard: As far as a response goes, as Professor Murphy has said, and I think that it was pointed out in the minister's media releases as well, it's going to be very important that we develop an approach to addressing HTLV-1, and that's going to commence with a forum that will be established fairly soon chaired by Professor Murphy, who might want to talk a bit more about that. We need to determine the appropriate elements of any response or next steps. At the moment, as you pointed out, Senator, what is going on is a bit of research in Central Australia and northern Australia in relation to HTLV-1, but we believe we need to take it further than that.

Senator DODSON: I'm not opposed to research. I'd just like to see when we get to the action.

Ms Appleyard: Yes.

Prof. Murphy: What we're doing now is epidemiological work to determine what action is possible and necessary because, at this stage, there is no known treatment for this condition. The only management that some countries who've had endemic populations have done is try and reduce the transmission, but that is a complex issue. So, at this stage, we really need to understand the epidemiology properly.

Senator DODSON: Are we collaborating with the international work that's going on in this space?

Prof. Murphy: I had a meeting with the WHO last week in Geneva. I met with the head of their retroviral section, and we convened a special meeting at Australia's request with experts from Japan and other places, and we've encouraged the World Health Organization to do a technical workshop later this year, which will probably be in our region, to bring together people to learn from them. The Japanese probably have had the best experience at reducing transmission, and they've had a longer clinical experience than we have. And there are other countries in the world where it is endemic, particularly often in Indigenous populations, so we'll get together a group of world experts for that purpose. But we're not waiting for international action: we're planning local action.

Senator DODSON: I appreciate that. I'll have some questions on notice because I'm getting the wind-up here, and I appreciate that you guys have had a long day. How much of the $8 million will go to Aboriginal Community Controlled Health Services to manage HTLV-1?

Prof. Murphy: At this stage, that's to be determined. The money's only just been announced. The minister has asked us to convene a taskforce to plan what we do in this space. We will obviously be engaging the Aboriginal Community Controlled Health Services in studying the epidemiology. At this stage, in terms of control and management, it's not clear what that action would be until we better understand the epidemiology, but we will be working very closely with them. In fact, the summit that we're convening, probably in Central Australia in a few months time, will be in partnership with Aboriginal Community Controlled Health Services. We've learned, very much from the syphilis response, that they are a key partner in any of these responses.

Senator DODSON: Thank you. I'll have some questions on notice.

Senator SIEWERT: I'd like to ask about Lyme-like disease or vector-borne disease. I understand that the forum has now been held?

Prof. Murphy: Correct—the first of two forums, I should say. The first forum was largely with a medical community to try and bring chief health officers, college presidents and others to understand the need for multidisciplinary clinic approaches. We had representatives of the patient groups there. But, because the nature of that first forum was to socialise this concept with them, some of the community representatives feel that they would also like to have a forum where they can have an open invitation, so I'm going to convene a forum with all the patient support groups in Sydney later this year.

Senator SIEWERT: Do you have a date for that yet?

Prof. Murphy: I don't know that we've got a date at this stage, no.

Ms Appleyard: No.

Senator SIEWERT: Could you take that on notice?

Ms Appleyard: Yes.

Senator SIEWERT: Can you outline the outcomes from the forum?

Prof. Murphy: I think the principal outcome from the forum was the model of care that was piloted at Austin Health in Melbourne by Professor Grayson. A multidisciplinary approach was piloted where the approach is to not assume any particular diagnosis for people with this symptom complex, to go through a full multidisciplinary assessment, going back to

basics, looking at their symptoms and their signs and fully investigating. And, as, I think, we've reported previously, that clinic has found a significant proportion of people had other diagnosable conditions, some of which were treatable, with a strong focus on managing also the psychological distress of people who have been suffering from this condition for a long time. There was a discussion about the need for improving education and awareness amongst general practitioners, obviously, to provide further education around tick bites and management of tick bites. But we did start the forum with the position that, at this stage, we still don't have convincing proof that this group of people with severe, debilitating symptoms do have a tick-borne infectious disease. We took the position that further research is needed, and we know the NHMRC is planning to do some work in that space. We had a good discussion with the colleges and the state chief health officers, and they are very keen to see a formal evaluation of the work that Austin Health has done. We're hopeful that some other jurisdictions might look at setting up these clinics. At this stage they're a bit wary about the process, but we certainly had a strong buy-in from the College of Physicians and the College of General Practitioners about the need to do education amongst those professional groups, and we have to work out a way of doing that.

CHAIR: Thank you. In terms of where to from here, you just said you have to work out a way of doing the education and awareness. Were there actions committed to?

Prof. Murphy: I think we're still working with the colleges on that. I think we're also waiting for the second forum to make sure that the patient groups more broadly are happy with the approach that we will take. So we haven't got definitive actions coming out of it at the moment until we've had the second forum.

Senator SIEWERT: So there's no follow-up coming with looking at other clinics and looking at the clinics from, for example—

Prof. Murphy: We have asked each of the states and territories to go away and look at whether they would be prepared to set up a similar clinic, and they're considering that. They haven't come back to us yet. But, in terms of specific action around education of general practitioners and physicians and other people, we will determine that after the second forum, because we want to discuss these ideas more broadly with the patient groups. They felt that the limited number of their representation at the first forum meant that they haven't yet had a full opportunity to input into that.

Senator SIEWERT: So will you be writing up where you got to with this forum?

Prof. Murphy: Yes.

Senator SIEWERT: And then circulating it to the—

Prof. Murphy: We can put it on the website, and we can certainly circulate it.

Senator SIEWERT: What's the time line for that?

Ms Appleyard: We would expect that to be in the near future.

Senator SIEWERT: Thank you. In terms of looking at the multidisciplinary clinics, you said the states are still wary of that.

Prof. Murphy: Yes.

Senator SIEWERT: Are they looking at experiences from overseas where there are such clinics as well as the Austin?

Prof. Murphy: We didn't specifically discuss that in detail on the day. I had to miss half an hour, though, because I had to go and have my flu shot with the minister on TV.

Senator SIEWERT: Fair enough.

Prof. Murphy: But I believe that the focus was mainly on the Austin clinic model and also the experiences of Dr Schloeffel, who is a GP who works in this area. He presented his work as well.

Senator SIEWERT: Thank you. In terms of working with the states and territories, is the department going to be looking at some of the other clinics overseas so they can provide that information? Has anyone from the department visited them?

Prof. Murphy: We have no current plans to do that. If you can suggest any, we could explore them, but we think we have sufficient medical expertise in Australia to be able to plot a path forward.

Ms Appleyard: I think that, in addition to the patient groups that we'll be consulting with, there are a couple of overseas experts that the patient groups often talk about, so we would certainly be consulting with them, as we had done for the first forum as well, just to seek their input and their views.

Senator SIEWERT: In terms of their experiences or knowledge?

Ms Appleyard: Just their ideas in terms of how integrated clinic models could work et cetera. That's very much keeping good faith with patient groups in terms of bringing the full range of experience to the table.

Senator SIEWERT: Thank you. I'd like to move on to looking at the work the department commissioned of the National Serology Reference Laboratory. Has that been done?

Prof. Murphy: It has.

Senator SIEWERT: Is it finished?

Prof. Murphy: Dr Lum is our resident expert in serology, and he would be very happy to describe the findings of that report, which has been finalised and circulated and discussed with all the relevant stakeholders.

Dr Lum: The NRL evaluation of the in-vitro diagnostic devices that are used in Australia for the diagnosis of classical Lyme disease was conducted over a few years but finished at the end of last year. At the end of last year, there was a teleconference held that the Chief Medical Officer, Professor Murphy, chaired. That involved patient groups. There were also invitations sent to all of the states and territories as well as the relevant medical colleges. The report itself has been uploaded on the departmental website. The breakdown of the report reveals that, of the assays that are used in Australia, by and large, they are quite reasonable at making a serological diagnosis of classical Lyme disease. We used specimens from Australia. We also sought specimens from the United States, Germany and the United Kingdom. We were fortunate to have a panel of 100 specimens from the rare and imported pathogens laboratory from Public Health England, at Portland Down, and they were used as a reference panel for comparing results of the assays to other specimens. We also used a negative control panel, which was made up of blood donor specimens from donors from Tasmania who were asked specifically if they had ever left Australia. If they had not left Australia and if they were a

regular donor, then there were about 308 specimens from the Australian Red Cross Blood Service that were used as negative controls.

One of the findings was that two of the in vitro diagnostic devices, which are no longer used currently by any pathology practice in Australia, did have reduced sensitivity and specificity, and that was largely because they used native antigens from borrelia burgdorferi sensu stricto. The more modern in vitro diagnostic devices use recombinant proteins, and those assays that use those recombinant proteins were found to be more accurate—that is, they were more sensitive and more specific. The outcome of the evaluation revealed that the assays that are used in Australia are, by and large, quite good at making a diagnosis serologically of classical Lyme disease.

Senator SIEWERT: When you say 'by and large', what do you mean?

Dr Lum: If I went to an endemic part of north-east United States, was bitten by a tick and developed classical Lyme disease and came home, I'd be very happy having that diagnosis made using any of those assays being used by any of the Australian accredited pathology providers.

Senator SIEWERT: So why qualify it with 'by and large'?

Dr Lum: There were nearly a thousand specimens. There were 10 in vitro diagnostic devices. I can't remember off the top of my head exactly which IVD ended up being the better performer, but the difference in terms of performance was marginal, except for a couple of IVDs, as I mentioned, which were using native proteins, not recombinant proteins.

Senator SIEWERT: And those aren't used anymore?

Dr Lum: They're not used anymore.

Senator SIEWERT: So when you said 'by and large', you mean just the variety of the tests—you would be confident?

Dr Lum: Yes.

Prof. Murphy: I think we're confident that the testing in Australia is as good as anywhere in the world, if not better. There's no evidence that the testing is not performing to international standards.

Senator SIEWERT: Thank you. Is all the data that was used to draw those conclusions in the report online?

Dr Lum: No. The raw data was not made part of the actual report. The aim is for the former director of the National Serology Reference Laboratory, as well as the relevant scientists who were involved in the evaluation, to publish that work in a peer-reviewed journal. It's normal practice not to share raw data for any research work or any investigation until there's been a formal publication.

Senator SIEWERT: Do you know the time line for that?

Dr Lum: I don't have an exact time line. A lot depends on the journal that will accept the paper and then the time lines in terms of publication.

Senator SIEWERT: Okay. Are we talking six months, 12 months?

Dr Lum: Honestly, I can't tell you.

Prof. Murphy: We could ask the authors for an update on notice if you'd like.

Senator SIEWERT: You'd be aware, as I am, that there are many people taking a very intense interest in this, and the sooner that data is available, the better.

Prof. Murphy: We'll seek to find out what the progress of the publication is.

Senator SIEWERT: If you could take that on notice, that would be appreciated.

Dr Lum: Yes.

Senator SIEWERT: You had a phone link-up with stakeholders at the end of last year?

Dr Lum: Yes.

Senator SIEWERT: My understanding is there were some questions still remaining.

Dr Lum: Yes.

Senator SIEWERT: How many were there, and have they all been answered?

Dr Lum: From memory, there were three main groups of questions and roughly 35 or maybe 40 in total, depending on how you break it down. The issue is that one of the particular communications that we got wasn't a series of questions; it was a long statement. So we tried to break that down into a series of questions. I've been through the technical aspects of those questions with the former director of the National Serology Reference Laboratory. The answers to those questions are still going through a clearance process within the department, and we hope that they'll be available soon.

Senator SIEWERT: That's all of the questions?

Dr Lum: Yes.

Senator SIEWERT: Can I just go back to the tests very briefly. Do I take it, from what you've said about the conversation we've just had about 'by and large', that you are confident they're 100 per cent accurate? So, if someone gets a negative, that is a definite negative?

Dr Lum: I must qualify that by saying that no pathology test is 100 per cent accurate.

Senator SIEWERT: Fair enough.

Dr Lum: Within the realms of statistics associated with the particular disease and the particular testing, they are as good as you're going to get. These are the antibody serology tests that are used world-wide, and, in the hands of accredited pathologists and medical laboratory scientists in Australia, those tests are performing as expected, according to the manufacturer's instructions.

Senator SIEWERT: As to the need for repeating the test, is there any need for anybody, if they've got a negative response, to have a follow-up?

Dr Lum: Going back to a basic premise, these tests should only be used on patients who've got symptoms that are consistent with classical Lyme disease. On those particular patients, if they've got signs and symptoms and an exposure history that's consistent with classical Lyme disease and if they receive a non-reactive result, then it's not unreasonable, if the testing was done shortly after the tick bite, to look at doing the test again in perhaps seven to 14 days. At that stage, if it really is Lyme disease, there's a higher likelihood that you'll start to find antibodies. But there's no value in repeating it repeatedly, and a repeat negative basically suggests that the diagnosis is not Lyme disease. We need to remember that, even though somebody might be in an exposure or an endemic area where they've been exposed to ticks and may in fact have had a tick bite, there are other causes of annular rashes and, while a

bullseye rash is pathognomonic in those endemic areas, for the Australian context, when our medical practitioners are not used to that, it would be inappropriate just to make a diagnosis based on a rash.

Senator SIEWERT: Yes, and we've had these conversations before. I take your point. So, if we're talking about classical Lyme disease, what you have just said holds.

Dr Lum: Yes.

Senator SIEWERT: If we're talking about Lyme-like or other vector-borne diseases, these tests aren't necessarily appropriate?

Dr Lum: These tests are no use at all.

Senator SIEWERT: Can I go back to the issue around education and awareness-raising. Professor Murphy, you said that you want to wait until a second forum.

Prof. Murphy: Yes.

Senator SIEWERT: Is the intention then to work with the patient groups—

Prof. Murphy: And the colleges.

Senator SIEWERT: and the colleges to come up with a campaign or a process for increasing awareness and educating GPs and doctors?

Prof. Murphy: Yes.

Senator SIEWERT: As you're aware from the Senate inquiry, the lack of awareness was a really big issue.

Prof. Murphy: Sure.

Senator SIEWERT: So is that the intent?

Prof. Murphy: It is the intent.

Senator SIEWERT: Over what time frame? And is funding available?

Prof. Murphy: Well, there's no specific funding available at the moment, but we may be able access some funds to develop that. We have to scope it first and then see what it would cost. The colleges are very happy to engage and help support in such education programs. We had good buy-in from the colleges. In particular, the College of Physicians was very well represented at this forum—physicians probably see a lot of these people—and they were keen to be involved in education in the future.

Senator SIEWERT: Thank you. When the peer reviewed paper is available, that will obviously be in the journal and some journals—you may be shocked to learn—a lot of patients and patient groups don't have access to. Will it be possible to make that article very widely available?

Prof. Murphy: I'm sure we could make it available to the patient groups. I mean, there are sometimes copyright issues in that, but I think they—

Senator SIEWERT: That's one of the reasons I'm asking. As you know, we're talking about, in some cases, people that are on low incomes, and it's very difficult to access some of these journals.

Prof. Murphy: But we could certainly make available copies to the leaders of patient groups, and they may choose to distribute.

Senator SIEWERT: Okay.

Prof. Murphy: We wouldn't want to be breaching copyright as a government agency.

Senator SIEWERT: I understand that, but again this is data that's actually publicly funded, and my understanding is that this cost quite a bit of money to study. So if patient groups can't get access to the information that public money paid for, it seems—

Prof. Murphy: More and more journals now have open access policies, and it may not be an issue.

Senator SIEWERT: Okay. If it is, we have the undertaking that it will be made available?

Prof. Murphy: We can sort out a way of getting the information.

Senator SIEWERT: If you can't tell me now, could you take on notice the cost of the study—the investigation?

Prof. Murphy: We can take it on notice.

Senator SIEWERT: That would be very much appreciated. Thank you.

Senator DEAN SMITH: I'd like to go back to the line of questioning that Senator Dodson had, just in regard to the response to the syphilis outbreak. I think you said you would provide the information on notice in regard to the age groups, but could you tell us what is the predominant age group?

Prof. Murphy: It is still 15 to 29-year-old age group that is predominant.

Senator DEAN SMITH: You also mentioned that certain training was being provided. Can you provide a bit more of an explanation in terms of what is the nature of that training?

Ms Appleyard: I can start that description. There is certainly training in relation to their use of the point-of-care tests that are going to be deployed, and also, you know, obviously appropriate cultural awareness training because of the fact that services are being delivered to Indigenous people in remote and very remote communities as well. Also, there are health promotion and prevention activities. So it's part of not only training for patients or consumers but also for health professionals as well. But Mr Carlile may have some more explicit advice.

Mr Carlile: Certainly, that's the case. The intention is that we're actually upskilling the workforces within the Aboriginal community controlled health services. So, whilst it's a focus on syphilis, it's sexual health in general that will be upskilled and training provided on so that when the enhanced response is over, there will be a workforce that has been upskilled within the community controlled health services.

Senator DEAN SMITH: So how much people do you expect would be trained over what period?

Mr Carlile: The process is that we're inviting the ACCHSs in the outbreak regions to tell us what workforce supplementation they need. The training that's going to be provided will be done through a train-the-trainer type model and will be made available to all of the ACCHSs within the outbreak region. So whilst there will be a focus on some particular ACCHSs, who will develop a supplemented workforce, the training will be available to anyone who wants to send people along to that to access it.

Senator DEAN SMITH: Okay. Professor Murphy, you said that you were going as quickly as possible in the response—your words—and that you weren't limited by financial barriers. So what are the weaknesses in the response, do you think?

Prof. Murphy: We were very clear to not go barging into communities without appropriate engagement with the local ACCHSs, appropriate cultural sensitivity and appropriate preparation. We wanted to make sure that we had a program that was accepted by the local communities and the local health services that was properly equipped and able to respond. It does take time: we had to evaluate and procure a point-of-care test; we had to then get stocks of that; we had to then go and engage all the ACCHSs, and, specifically find those that were willing to get going early, and, as Mr Carlile says, train up the staff; and we had to procure antibiotics, because the plan of this is that once you get a positive test you treat the person on the spot with antibiotics—that's a really critical part of it. The last thing we wanted was to have a response that had any rejection from communities or wasn't culturally sensitive.

Senator DEAN SMITH: Did some ACCHSs not want to participate?

Prof. Murphy: I think there were some that were a lot more enthusiastic at the start, but I think more and more are coming on now.

Senator DEAN SMITH: Really? Why would an Aboriginal controlled health service not be interested in combatting syphilis?

Prof. Murphy: I think they were interested in combatting it, but some of them needed some convincing about the model. They didn't feel that an enhanced-response model with test and treat was what they thought was appropriate. They perhaps saw it more in the lines of an intervention and were a bit wary about it. So we've had to convince them that this is—

Senator DEAN SMITH: But you are the Chief Medical Officer of the Commonwealth, Professor Murphy.

Prof. Murphy: Yes, indeed.

Senator DEAN SMITH: That should have standing in itself?

Prof. Murphy: But we had to work with them. We are working them, and they're pretty much all coming on board now—some much more enthusiastically than others. We had to reassure them that we weren't going to bypass their processes, and, at the same time as we were doing an enhanced response, we were upskilling their staff and making sure that there was a sustainability path.

Senator DEAN SMITH: I appreciate the sensitivities you're alluding to, but that's not to excuse for the hesitation that some might have.

Ms Appleyard: Probably the other thing it's fair to say is that some of the ACCHSs really think they're quite on top of this response, because they've been working in this area for some time.

Senator DEAN SMITH: You're not a health professional, Ms Appleyard. Are they on top of this response?

Ms Appleyard: I can think of one in particular in the APY lands, Nganampa, who has had—

Senator DEAN SMITH: One out of how many is on top of the response? That's the point.

Ms Appleyard: Well, I'm just giving that one example.

Senator DEAN SMITH: Yes, thank you. When I asked the official to explain the training—how many and over what period—the response I got was, 'We're still inviting.' In March 2017 this issue was first raised at Senate estimates.

Prof. Murphy: Sure.

Senator DEAN SMITH: You know my position. It really comes down to an issue about whether or not we are responding thoroughly enough. I appreciate the challenges, and part of the job here is to perhaps tease out what some of those challenges or weaknesses are, to make sure that all those relevant bodies are coming on board.

Prof. Murphy: I think we can say confidently now that all of the ACCHSs are on board, other than perhaps Nganampa, which don't need to be on board because it has the problem under control; it doesn't have a prevalence. The others are all on board now. But there is a process of bringing them on board, and some are more open to it than others. But we have no barriers now; it's just a matter of getting the train moving.

Senator DEAN SMITH: Professor Murphy, in your earlier contribution you said that the Commonwealth was putting its effort into frontloading the response. I understand that. You correctly highlighted that, fundamentally, this is a state and territory responsibility, and I accept that. You alluded to the issues around sustainability into the future. At what point do you think we'll be able to break the back of this particular syphilis issue?

Prof. Murphy: I think it will take some years, probably. I hope we would start to see the epidemiology responding within six to 12 months, but I think we will need an enhanced response to be going for some years before we can confidently move into a sustainability path.

Senator DEAN SMITH: So you expect the Commonwealth's involvement to be required for a number of years?

Prof. Murphy: I think so, yes. We will have an ongoing role anyway in that we support the ACCHSs. So it will always be a partnership with the states and territories. We primarily fund ACCHSs.

Senator DEAN SMITH: Mr Carlile, you correctly alluded to the point that this is just one element of a broader issue in regard to sexually transmitted infections in Indigenous communities. Secretary, are you satisfied that enough is happening and enough is happening quickly enough around this particular issue? We're dealing with other sexually transmitted infections in Indigenous communities as well at rates that are hugely disproportionate. Are you satisfied that enough is being done and resourced?

Ms Beauchamp: I think there's always work to do and always improvements to be made. Through AHMAC I think we've got a process in train now where we can mobilise resources on the ground—and the states and territories. It's not just the ACCHS but also the states and territories. We can play a leadership role in the better coordination and better mobilisation of efforts. I think the reference group that the Chief Medical Officer's chairing provides strong governance to do that.

Prof. Murphy: Senator, I think it's important to note that as part of the syphilis testing, where possible, we'll be testing for other STIs. The additional $8 million recently announced

which is primarily focusing initially on HTLV-1 is earmarked for emerging communicable diseases in Indigenous communities. We will have access to use some of that if we need to.

Senator DEAN SMITH: You will be testing for other STIs?

Prof. Murphy: Where possible. If you're going out in a remote community—

Senator DEAN SMITH: I've been to remote communities.

Prof. Murphy: it may only be possible to test for syphilis. But where the testing is done, as it will be in some cases, in a medical centre, we'll try to take serology and test for that at the same time.

Senator DEAN SMITH: What opportunity is there to use MBS schedule item 715, which is specifically around Indigenous health?

Prof. Murphy: We have been in discussions with the Indigenous Health Division and the MBS review about the potential for making STI tests a mandatory part of that. The challenge is that it's probably only relevant for certain age groups. How we enhance the use of that test to—because at the moment it's a voluntary part of that.

Senator DEAN SMITH: I know, which is remarkable.

Prof. Murphy: There are some complexities around making it mandatory—

Senator DEAN SMITH: And some sensitivities; I understand that. You know my position around urgency. Things have happened in the last few months, but I'm firmly in your camp, Secretary, that much more needs to be done, because I think that Australians would be outraged if they knew the levels of disparity on this issue.

CHAIR: I believe that that is all we have on program 5.2.

Prof. Murphy: Chair, since we're on 5.2, could I make a clarification around comments made in outcome 1.5 yesterday to Senator Watt about the Ebola response? It actually fits into this outcome because it's part of health and emergency response. I want to clarify that both the secretary and I thought that the Prime Minister had announced that funding locally. While it was announced in Geneva, it was only announced this morning in Australia. I would like to clarify that, although the $4 million will be used to address the Ebola response, it's specifically to contribute to the World Health Organization's contingency fund for emergencies to enable WHO to quickly and effectively mobilise responses to outbreaks. That includes the Ebola response. So, that's the source, but it's a general contribution to that emergency fund, not money specifically earmarked for this Ebola response. It will be used by the World Health Organization.

CHAIR: The World Health Organization chooses how to—

Prof. Murphy: How to use it in their emergency response. They will almost certainly use most of it in the Ebola response, but it's up to them. The contribution was to that contingency fund. Any further information on that funding could be made available from the Department of Foreign Affairs and Trade.

CHAIR: Senator Watt, did you have any follow-up questions?

Senator WATT: No, that's fine.

Ms Appleyard: Could I make a correction to something Senator Watt had asked?

CHAIR: Certainly.

Ms Appleyard: It's just an addition. You asked me about the definition of an infectious syphilis outbreak case and if that was all Indigenous people. I said that it was. That is true, but sexual contacts of a confirmed outbreak case would also be included in the definition, and those sexual contacts may be Indigenous or non-Indigenous.

Senator WATT: Sexual contacts of a?

Ms Appleyard: Of somebody with infectious syphilis who lives within the outbreak area. If you're a sexual contact of one of those people—primarily that would be an Aboriginal and Torres Strait Islander person with infectious syphilis living in one of those four areas—and you have infectious syphilis, and you may be Indigenous or non-Indigenous, you would be a considered a case as well.

Senator WATT: They would be included in those figures that you gave me?

Ms Appleyard: That's correct.

CHAIR: Any further clarifications?

Prof. Murphy: No, thank you.

CHAIR: You'd almost think you didn't want to get out of here! On that note, we'll release program 5.2 insofar as you're not required for a later outcome.

[17:50]

CHAIR: We'll move on to program 5.3, immunisation.

Senator SINGH: I won't be too long. I understand that there are a number of senators here that are keen to move on to outcome 6. How many Australians have had flu vaccines so far this year?

Prof. Murphy: I'll get Dr Hobbs. I was happily in Geneva for two weeks during the last issues, so he has now become the expert on that.

Dr Hobbs: Thank you for the question. We can't be sure how many people have actually had a vaccine. We can only give you details about how many vaccines have been released into the system. The system is made up of three parts. The National Immunisation Program has had 5.1 million doses released—

Senator SINGH: Of flu vaccine?

Dr Hobbs: Of flu vaccine.

Senator SINGH: 5.1 million?

Dr Hobbs: 5.1 million this year to date. Then there's the private market. Also, this year each of the states and territories, except for the Northern Territory, have provided a program for under fives. In total at this time it's just under 10 million doses that have been made available across the country.

Senator SINGH: How does that compare to last year?

Dr Hobbs: Last year there were 8.3 million doses made available across the entire season, noting that we're not quite at the end of May this year.

Senator SINGH: That figure you gave me for last year, was that to the end of May last year?

Dr Hobbs: That was the entire season last year: 8.3 million.

Senator SINGH: What's the season? What are the dates?

Dr Hobbs: That goes right through to the end of last year.

Senator SINGH: 8.3 million to December last year?

Dr Hobbs: That's right. Most of those doses will be given—

Senator SINGH: What about to the end of May last year? In comparison to where we are now.

Dr Hobbs: I don't have those available. My colleague may, but I don't think so.

Prof. Murphy: I don't think we have that information.

Dr Hobbs: No.

Senator SINGH: What's the source of the data on flu cases?

Dr Hobbs: We're not talking about flu cases; we're talking about—

Senator SINGH: No, I'm asking.

Dr Hobbs: You are. To date, it's very early in the season and we don't have any reliable data through. I will pass over to my colleague.

Prof. Murphy: Flu data is always an estimate. We have a number of surveillance methods that are in place—hospital-based admissions to get confirmed, general practises that are involved in surveillances and a flu-tracking process that a university runs—but it's always an estimate because you cannot confirm that someone who's had an illness has got flu unless you've had proper virological confirmation. We have data on suspected flu-like illnesses and data on confirmed flu cases. Those datasets are the same from year to year. We can compare, year by year, the number of confirmed cases and get an estimate of the true prevalence of flu, but we can never accurately determine the total number of cases each year.

Senator SINGH: Do you report on them throughout the season?

Prof. Murphy: We report fortnightly throughout the season on the number of confirmed cases and data on hospital admissions and severity. Clearly, we had a significantly worse season than usual last year, as we reported through the season.

Senator SINGH: What accounts for that? What accounted for the—

Prof. Murphy: The worst season last year?

Senator SINGH: worst season last year?

Prof. Murphy: That's still very familiar in my mind. There was a predominance of a particular flu strain called H3N2, one of the A strains. That particular strain was very prevalent, but has a predominance of infecting elderly people. The vaccine last year provided a particularly poor immune response for the elderly population for a number of reasons. One, generally, the elderly don't produce as strong an immune response to the standard dose vaccines, and, two, because that particular A strain underwent what we call an antigenic shift: it mutated a little bit, so it was not well covered by the vaccine anyway. Particularly for the reason that the elderly don't produce such an immune response is why we've introduced this year—in pretty much record time; we made the decision late in the season last year—these two new enhanced vaccines, one of which has what's called an adjuvant which boosts the immune system and the other one has four times the dose of virus that kills virus. For the over-65s this year, we've introduced a vaccine that's much more powerful.

Generally, when you have a bad season, you don't have as bad a season the next year. We probably won't see so much of this H3N2 because the community had a lot of exposure last year, but you can never be sure. Seasonal influenza is always unpredictable.

Senator SINGH: So are you saying you don't expect this year's demand to be greater?

Prof. Murphy: The demand for vaccine is substantially greater, because of people's concerns about last year's season. It's just too early to tell this year whether the season will be as bad as last year. However, history would generally suggest that, when you have a really bad season one year, you don't have as bad a season the next year but that's not always the case.

Senator SINGH: So the department obviously expected this year's demand to be greater, which I think you've just acknowledged. Did you therefore provide the minister with any estimates as to this increase in demand?

Prof. Murphy: The demand was worked through with each of the states and territories. At the end of each flu season, they provide an estimation for the coming season based on historical trend data and their population, what they think the demand might be for the next season, noting the qualifications that Professor Murphy has already put on the table. Generally, across the country, the jurisdictions came back with about 10 per cent increased demand for this year. Clearly, it was suggested that the demand, in conversation with the chief health officers of the states and territories which commenced the week before last, is sitting somewhere between 25 to 30 per cent on last year—so really much higher than expected. As I said, that's for a number of reasons. One is: expectation of these two new vaccines coming through. We know that already on the national immunisation program we've released 3.4 million doses of those advanced trivalent vaccines. That's enough to cover 85 per cent of the over-65 population—very important. We've already released almost 10 million doses across the system—that's already about 19 per cent up on last year—and, with the 800,000 extra doses coming into the system which are being procured both offshore and by the restarting, if you like, of the local onshore facility at Seqiris in Melbourne, those 800,000 doses will take it to around a 26.5 per cent increase totally over what was made available to the population last year.

Senator SINGH: What's the process for making vaccine orders?

Dr Hobbs: I might pass over to my colleague Dr Somi.

Dr Somi: Orders are placed with the pharmaceutical companies. We go through competitive tender processes on a regular basis and establish market shares and then, on an annual basis with discussion with the states, we do provide the estimates of what we'll procure for the national immunisation program. States separately—

Senator SINGH: Do the states put in their orders based on what their advice is from their health departments?

Dr Somi: Yes. They would advise us what they would require for eligible cohorts on the national immunisation program. They would also work directly with pharmaceutical companies to procure supplies for their own state programs, and pharmaceutical companies obviously estimate what they think they would like to bring in for the private market based on discussions with wholesalers.

Senator SINGH: So, once the states have put in their orders, what happens? Does the federal government simply order the number requested?

Dr Somi: That's correct; yes, we do. Based on the advice of the states—

Senator SINGH: Is there any oversight or discussion about the numbers?

Dr Somi: I'm not sure what you mean by discussion. Are you—

Senator SINGH: With the states. We've had this increase in demand, so I'm trying to work out what the process is.

Dr Somi: Are you asking: would we go back and test them and ask them—

Senator McKenzie: They tell us formally what they need under our programs and we order that amount for them. If they've got their own state program, they have to put that order in themselves.

Senator SINGH: You simply order what they—

Senator McKenzie: What they've told us for our programs.

Prof. Murphy: I think it's important to note that whilst we procure the vaccines for the National Immunisation Program the states are responsible for delivering the program, and they are responsible for estimating the demand. So it's a partnership agreement. We are the procurer and purchaser of the vaccine—

Senator SINGH: Yes, I understand that. Does the minister play any role here? Does he have any powers in assessing or changing these orders?

Dr Somi: No—

Senator SINGH: Does he question the figures that the states have put in?

Dr Somi: He wouldn't see—we wouldn't provide those details to him.

Senator SINGH: Okay. So vaccines are now being rationed. Who can get them and who cannot?

Dr Hobbs: Maybe I could answer that? Working with each of the chief health officers, we have had now had four meetings over the last 10 days. They're responsible for the supply of the vaccine on the National Immunisation Program. They work with their providers—that will be general practices and Aboriginal medical centres—to work out how that distribution will work against demand.

What will happen is that each general practice or AMS will put in an order for, say, 100 vaccines on the National Immunisation Program, and it will be up to those jurisdictions to then release that vaccine according to how much vaccine they have in stock and where they are in the season. We have seen the jurisdictions working to manage that supply ongoing, noting that that's the National Immunisation Program. Then there's the private market, where you source a vaccine through a community pharmacy, for instance. And, of course, the other system that's in play this year—right across the country, with the exception of the Northern Territory—is the under-five program, which each of the jurisdictions are supplying.

Senator SINGH: Why was it allowed to get to this rationing stage before more vaccines were ordered? Obviously, Professor Murphy has already said that there was an expectation there would be a higher demand this year—

Prof. Murphy: But this was an unprecedented demand, Senator. I think—

Senator SINGH: Why could you not see this season would demand—

Prof. Murphy: I think it's important that all the experts in every state would have predicted about a 10 per cent increase. We have not seen this unprecedented demand. If you go back, even after swine flu there wasn't this huge demand the next year. There was huge media attention last year. With the benefit of hindsight, maybe the states and territories could have predicted more. The response, as soon as the vaccine shortage was made known—it happened when I was flying to Geneva, which was very convenient!—was that Dr Hobbs immediately convened a meeting of the Australian Health Protection Principal Committee. As soon as there was any hint of shortages responses were put in place from that moment.

So there has been no delay in responding. As soon as the states notified us that there were any issues, we have been working to procure extra vaccines. That extra 800,000 will have a material impact when they come.

Dr Hobbs: That's correct. And, if I may say so, already we have released almost 500,000 extra doses of vaccine to each of the states against their predicted requirements. Of course, these extra 800,000 doses are coming in both from the offshore procurement and from Seqirus in Melbourne in coming weeks.

Senator SINGH: When will those new vaccines be available? And will they be enough to end this rationing?

Dr Hobbs: Of the 300,000 to be procured offshore, 93,000 of those doses were one of the enhanced trivalent vaccines. They've already come into the country and been distributed to each of the states and territories. We have worked out apportioning in conversation with the chief health officers. An extra 156,000 doses of the quadrivalent vaccine for the three-year and up cohort will come into the country in the coming days. We expect that to be distributed once cleared by the TGA, the Therapeutic Goods Administration, very early in June. Then there is an extra 80,000 doses also being secured. That one also has to go through the regulatory arrangements. That's for the 300,000-plus doses of vaccine being procured offshore.

Seqirus have committed to supplying an extra 500,000 doses of their locally manufactured vaccine, and that will be available in early July. Very importantly, we know that the peak flu season is really late July, August and September, and it takes around 10 to 14 days to achieve a good immune response after a flu vaccine, so there is still significant time for those in the community who haven't had a vaccine to be able to have it.

CHAIR: Is there any sense that you could ever achieve enough uptake of flu vaccine to get some sort of herd immunity? Or is it the case that because it's a yearly outbreak you just can't do it?

Prof. Murphy: No, you theoretically could. The trouble with the flu vaccine is that it's not a totally effective vaccine; it's only partially protective, because it's such a strange and clever virus and it mutates all the time. It's reasonably effective. We certainly now have pretty good coverage in the over 65s, and if this new vaccine works well we should get protection. The challenge is getting enough coverage—particularly in young children, who are the superspreaders of the virus—to get good herd immunity. That's why the states have introduced their own programs. Traditionally in the past there's been very poor uptake in the under-fives. One of the surprises this year is that there's been higher uptake than we expected,

and that suggests that there might be some more herd immunity. But you would need at least 30 to 40 per cent coverage to get some sort of protection against transmission. I don't know whether Dr Somi wants to comment on that.

Dr Somi: I would just say that in some countries overseas that have introduced childhood programs, mostly targeted at primary care and secondary school, achieving coverage rates of 40 or 50 per cent does result in reduced hospitalisations across the population, including across the elderly. The 40 to 50 per cent seems to drive impact across the population.

CHAIR: What's the response curve? If you go from 60 per cent to 80 per cent do you get an exponential decrease in the hospitalisation rate, the seriousness? Is there some point at which the herd immunity maxes out, I guess—reaches its peak effectiveness?

Dr Somi: Are you talking about coverage in the elderly or in adults? There isn't that same level of evidence as I'm discussing for the younger children, where the evidence has been quite comprehensively researched in the UK and in the US.

CHAIR: So, it's been comprehensively researched in younger children?

Dr Somi: Yes—primary school and high school.

CHAIR: But not in the elderly? That surprises me.

Dr Somi: I think there's research about direct protection: if I'm vaccinated, what's the level of protection I can receive in terms of vaccine effectiveness? The impact of the herd effects has not been demonstrated amongst the elderly.

Prof. Murphy: But the children are the major spreaders. There's good evidence to suggest that they're the people who spread it more aggressively in the community because they get it and they're more mobile and they spread it more aggressively. From the work overseas in children, the best hope for herd immunity in children is probably if the promise of the inhaled what we call live attenuated vaccines comes to fruition. In the UK the reason they've been able to get some high uptake is that they're using this vaccine where they can just go around a schoolroom and sniff it and they get vaccinated. It's a live virus that is altered so that it doesn't cause disease.

But bringing children in every year for an injection is quite a challenge. Western Australia's been doing it for several years and they've had only about 10 per cent uptake. We offer it to Aboriginal and Torres Strait Islander children under five and we get only a 10 per cent uptake. It's interesting that the response in some of the state programs has been more than that this year because parents were pretty anxious after last year. But ultimately that may wane again. The idea of bringing a kid in every year for a flu vaccine when they've got all their other vaccinations to get is challenging. So, we're hopeful that this inhaled vaccine might be possible in the future.

Then, of course, the Holy Grail is the universal flu vaccine—not targeting those things on the virus that change, that can mutate but targeting a part of the virus that is constant all the time. There's quite a lot of work happening. It's still early, but there's reasonable confidence that, in the next decade or so, we might get a universal vaccine that will protect year on year from one or two or three doses and give continuous protection. That's probably the best way. Given that there is likely to be another flu pandemic in the future, there's a lot of interest in trying to get that done because if the community could be protected universally, we would also be protecting against a pandemic.

CHAIR: How do Australian immunisation rates compare to international rates?

Prof. Murphy: We'd have to get that on notice, I think, unless Dr Somi knows.

Dr Somi: It's quite challenging to compare immunisation coverage rates. We are one of only two or three countries that have a register that covers the entire population, so we're quite privileged. Other countries use self-reported surveys, which are much less reliable. We're one of the few countries that actually measures coverage in adults, which is obviously the population of interest in influenza.

CHAIR: In the high-risk age group, which I assume is 65-plus, do we know what coverage rates—

Prof. Murphy: As Dr Hobbs said, we assume we are going to get 85 per cent coverage this year because we have distributed vaccines sufficient to cover 85 per cent. They're all going.

Dr Hobbs: There are two self-reported studies in the literature, from 2009 and 2014, sitting at around 74 per cent of the targeted population over 65 having had a flu vaccine that season. As we've already said, already this year we have released enough vaccine to cover over 85 per cent of that target population. So that's a very significant increase compared to previous years.

CHAIR: A fascinating topic.

Senator POLLEY: I have one question.

CHAIR: Yes, go ahead.

Senator POLLEY: We understand from experience that a lot of elderly people died in nursing homes and residential care through the flu epidemic that we had last year. It was mandatory for those people working in the sector to have the flu injection. With this rationalisation, are they considered to be a priority group?

Ms Beauchamp: Can I just clarify that? I think the mandatory component was for the service provider to offer a flu vaccine. It wasn't mandatory for every worker to have it.

Prof. Murphy: All aged-care providers now have to offer a vaccine. I think they would have offered it fairly early in the season. I have not heard reports that they're having difficulty, but others might know.

Senator POLLEY: Can you take it on notice to come back to us with the figures? That would be really useful.

Prof. Murphy: It would be hard to get the figures.

Dr Somi: I don't think we'd be able to provide figures. Do you mean figures in terms of unmet demand amongst that—

Senator POLLEY: Yes.

Dr Somi: I'm not sure we'll be able to collect that information, because those supplies would be sourced from the private market, and we don't monitor distribution or supplies in the private market except at a global level, as Dr Hobbs indicated earlier.

Prof. Murphy: But we do have aged-care forums. We could find out anecdotally whether they have had problems. We could certainly get some information for you.

Senator POLLEY: There was a significant number of elderly people who died last year.

Dr Somi: Certainly we've been meeting at my level with states and territories on a daily basis to monitor supply, and one of the questions we have been asking is on impact and whether they have been hearing about issues in the aged-care sector and others, and they've advised that they haven't.

CHAIR: I believe that may be all on 5.3. In that case, we can release all of outcome 5 insofar as they haven't left already and aren't required for a later outcome. I will have a quick discussion amongst the committee. Obviously we've only got 15 minutes to go before the break. Are we happy to kick off now or happy to have a slightly earlier mark, if that works for you, Minister?

Senator McKenzie: I'm in the committee's hands. I'm happy either way.

CHAIR: In that case, we'll suspend for an hour. We shall resume with outcome 6, on ageing and aged care.

Proceedings suspended from 18:14 to 19:16

CHAIR: It being just after 7.15 pm, we will resume the hearing. We have moved to outcome 6: aging and aged care. Senator Polley, you have the call.

Senator POLLEY: Thank you very much, Chair. Can the department explain what consultations with the sector were undertaken in the lead-up to the 2018-19 budget?

Dr Studdert: I think it is fair to say the department and the various elements of our aged care program were in constant consultation with the sector in relation to a range of services and programs that we're responsible for. Obviously, in relation to a budget process, there's an element of confidentiality around that that we have to respect in terms of the government and its processes. This package, as you would be aware, is part of a broader package across a number of portfolios around ageing and healthy ageing. My colleagues may add to this: in terms of specific budget measures, there was no consultation prior to budget; but a lot of the budget measures are now open for detailed consultation in terms of how they'll be implemented and taken—

Senator POLLEY: After the allocation of money?

Ms Beauchamp: We should mention there were a number of reviews that led to many of the announcements in the budget. The review process itself, whether it be the Paterson-Carnell review or the David Tune review, absolutely did involve comprehensive stakeholder engagement. In addition, the department, having responsibility for aged care, makes sure we talk to the sector providers and peak groups on an ongoing basis. Whilst we may not have been—

Senator POLLEY: But there was nothing specific to the budget?

Ms Beauchamp: Whilst we may not have consulted specifically on every budget measure, we had a pretty good indication of where the gaps were and what the sector was telling us. We were building on, as I said, the reviews that had been undertaken over the previous time.

Senator POLLEY: Can I also then ask you what the term 'existing resources' means in the budget? That's specifically on page 119 of Budget Paper No. 2.

Ms Beauchamp: Sorry, Senator, could I get the page number again?

Senator POLLEY: It is page 119 in Budget Paper No. 2, and the term is 'existing resources'. Can you explain to me what that terminology refers to?

Senator McKenzie: There are a lot of dot points on page 119. Is there a specific measure?

Senator POLLEY: It's a term that's used in relation to the funding—that is, 'existing resources'. The department would be, I'm sure, very well aware of what that means; but I'd like the explanation.

CHAIR: The context is important, so let them find—

Ms Beauchamp: Specifically, which dot point are you referring to?

Senator POLLEY: 'Existing resources' is a term that's used on page 119.

Dr Studdert: I just want to be sure we answer your question accurately, but we're not seeing those words.

Senator POLLEY: Does that mean that there's no new money coming in?

Ms Beauchamp: I'm trying to find—

Senator McKenzie: Actually, I've scanned all of 129—

Senator POLLEY: It's 119.

Senator McKenzie: Yes, 119. It is where the Better Ageing package is. I can't find the phrase 'existing resources'. It outlines the big measures of funding in the Better Ageing package. It's not on page 119, though.

Dr Studdert: There are some on 117.

Senator POLLEY: It could be a typo then, sorry.

Senator McKenzie: No, you're all right. Is that it, Dr Studdert?

Dr Studdert: We have gone back to the start of the section on 'More choices for a longer life'. On page 117, under 'Better access to care', which is dot point 3, there is a reference to $32 million from within existing resources.

Senator POLLEY: So what does the terminology mean in that context?

Mr Smith: That refers to funding within a program within the portfolio that has been diverted to this particular measure. It's existing funding within the portfolio that's been made available for this measure.

Senator POLLEY: So it's taken from existing pool of money, and there is no new money. I just wanted to clarify that.

Ms Beauchamp: That's for that $32 million which specifically relates to support for the Aboriginal and Torres Strait Islander Flexible Aged Care Program. That's coming out of the specific Indigenous health program that we spoke about yesterday.

Senator POLLEY: I might have to come back to that then, because that's not my understanding. If we can move on, can the department confirm that the $100 billion used by the government and the media in the lead-up to the budget is funding that was already allocated across the forward estimates?

Ms Beauchamp: Sorry, which figure are you talking about now?

Senator POLLEY: I'm talking about the $100 billion used by the government and the media in the lead-up to the budget. Is it funding that was already allocated across the forward estimates?

Dr Studdert: I don't think we're familiar with the figure $100 billion.

CHAIR: I don't recall that figure. Minister?

Senator McKenzie: $100 billion?

Senator POLLEY: Yes.

Ms Beauchamp: For the Health portfolio, in terms of what I said in cross-portfolio, there was $12.4 billion additional funding coming to the Health portfolio over the forward estimates. I also mentioned that the annual figure for the 2018-19 was $99 billion, which crossed the health, aged care and sports portfolio. I'm not familiar with the specific $100 billion that you're referring to, Senator Polley.

Senator POLLEY: Okay.

Senator McKenzie: For the entire portfolio—not just ageing, health and sport—it's a little under $100 billion, but that includes the sport package, the broader health measures and aged care in its entirety.

Senator POLLEY: Right.

Senator SIEWERT: It's everything for older Australians?

Senator McKenzie: No, it's everything for health and sport, including aged care.

Senator POLLEY: Can you explain how the Minister for Aged Care is able to say that funding for aged care will increase by $5 billion over the next four years? Why is the minister using this particular figure?

Dr Studdert: That is the growth in funding over the next four years. That is new money that will be in our appropriation for aged care over those four years.

Ms Beauchamp: I'll let the officers go through the detail. In our portfolio budget statement, total expenses for outcome 6 go from $17.2 billion in 2017-18 up to $22.6 billion in 2021-22. There's growth factored in each year over the period of the forward estimates.

Dr Studdert: Which sums to $5 billion.

Senator POLLEY: Can you outline the amount of total funding for aged care across each of the years in the forward estimates?

Dr Studdert: As the secretary just noted, page 134 of the Health portfolio budget statement lists the total expenses for outcome 6 for the 2018-19 budget as $18.7 billion; for 2019-20, $20.0 billion; for 2020-21, $21.16 billion; and for 2021-22, $22.66 billion.

Senator POLLEY: So has anything changed or was that already in the forward estimates? Is there any additional money there or is it what was already in the forward estimates from last year?

Dr Studdert: As you're aware, one of the budget measures this year was to combine two programs. This number has not been presented previously as a single number; it's been two separate numbers. The growth is now very clear for all of aged care over those forward years as a total pool of money for our aged-care services.

Senator POLLEY: Can I go back to that $100 billion. Prior to the budget, it was expected that $100 billion would be spent on increased in-home care for about 105,000 older Australians who still remain in their homes without the adequate home care package that they need.

Dr Studdert: To go back to your earlier question about the $100 billion: I think I can see now that if you added those years—probably the five years from 2017-18 to 2021-22—I don't have the sum in my head but it looks close to $100 billion. That may be where that figure came from. It's not one we've been using in our budget documentation.

Senator POLLEY: Can we move on to the Tune report. What was the cost to undertake the *Legislated review of aged care 2017* report? Were these funds departmental or administrative?

Ms Grinbergs: The funding to support the Tune review came from administered funds, and totalled $336,000.

Senator POLLEY: Can you confirm when the government will formally respond to the Tune report?

Dr Studdert: We can't say, frankly, when the government will respond. Obviously the budget package itself has quite a few elements that are direct responses to the Tune review. The minister has also indicated that there will be a response that will address the remaining recommendations that haven't been picked up in the budget package.

Senator POLLEY: Minister, are you able to enlighten us as to when there will be a response?

Senator McKenzie: No, but I know that the minister, in developing the aged-care package and measures in the budget, was aware of the Tune review and the recommendations within it, and will be bringing forward a formal response later on. As the department's already noted, a lot of the budget measures do deal with issues contained within the Tune review.

Senator POLLEY: Can you please outline to me which of the 38 recommendations had been adopted before the 2018-19 budget?

Ms Jolly: Certainly. I can give you the recommendation number and then the budget measure.

Senator POLLEY: I want to know what was before this budget. What recommendations were picked up in 2017-18 prior to this budget?

Ms Jolly: For example, recommendation 3 of the Tune review has a budget measure associated with it, which is about conducting an impact analysis of allocating residential aged-care places to consumers instead of providers. That budget measure also responds to recommendation 4 and recommendation 8(b). All three of those recommendations in the Tune review deal with that concept. There is a budget measure for more high level home care places, which responds to recommendation 5. For recommendation 6, which is also about high level home care packages, there's a budget measure of a combined flexible-aged care appropriation.

Senator POLLEY: This is for this budget. I wanted to know what recommendations were being put in place prior to this budget.

Ms Beauchamp: The package put forward in the 2018-19 budget primarily responds to the Tune review but the government did announce in September last year that it did not support recommendations 13 and 15, which seek to significantly increase contributions made by older Australians by including the full value of the home in the means test for residential care and by abolishing annual and lifetime caps on means-tested fees. The government

specifically announced that it did not support those. Many other recommendations from the Tune review have been picked up in this budget.

Senator POLLEY: In this budget?

Ms Beauchamp: In this budget.

Senator POLLEY: Can I stop you there. What you are saying is: no action had been taken prior to this budget, apart from saying, 'We're not going to accept recommendations 13 and 15'?

Ms Beauchamp: The report was only tabled on 14 September 2017, sometime after the last budget—

Senator POLLEY: Eight months ago.

Ms Beauchamp: so the first opportunity to acknowledge it in the appropriation process was this budget. As I said, the government did make announcements in September when the report was tabled, and I understand a formal response will be provided in due course. But most of the recommendations, as Ms Jolly was pointing out, have been picked up.

Senator POLLEY: If you can go back then to continue, Ms Jolly. After recommendations 5 and 6, are there any other recommendations? We've got 3, 4, 8(b), 5 and 6.

Ms Jolly: There's a budget measure improving access to aged care through My Aged Care. It responds to a number of recommendations: recommendations 11, 22, 24, 25, 35 and 36. All of those recommendations deal with improved information and functionality of the My Aged Care website. Recommendation 20 has been responded to, through a budget measure managing prudential risk in residential care, as has recommendation 21. Recommendation 23, which is around aged care system navigator and outreach, has been responded to through the budget measure for an aged care system navigator. In response to recommendations 26 and 27, there is a budget measure for streamlined consumer assessment for aged care. In response to recommendation 29, which is access to wellness and reablement, there's a budget measure promoting independent living. Recommendation 31, which is to expand the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, has been responded to through a budget measure of the same title. I also draw your attention to recommendations 13 and 15, which the government had previously indicated they weren't supporting.

Senator POLLEY: How many recommendations are still outstanding, to be acted upon?

Ms Jolly: There are 18 recommendations plus, I would say, a half a recommendation. So 8B has been responded to, but not 8A at this point.

Senator POLLEY: How many are still being considered by the government? They have ruled out 13 and 15. Can you advise me as to which ones they have seriously taken under consideration?

Ms Beauchamp: All the recommendations are seriously under consideration, and the government will respond in due course.

Senator POLLEY: So the ones that are left that haven't been responded to, your expectation is they will be responded to before the end of the calendar year?

Ms Beauchamp: I can't put a time frame on that, but they are seriously under consideration, and the government will respond in due course.

Senator POLLEY: I just want to be clear, there are no other recommendations other than 13 and 15 that have been ruled out?

Senator McKenzie: That's right.

Senator POLLEY: So we could assume then that the rest will be taken up at some time by the government.

Ms Beauchamp: They will be considered by government.

Senator McKenzie: The government will respond in due course.

Senator POLLEY: My understanding is over $8 million has been allocated to the communications campaign. Was this a decision by the government or an option put forward by the department to spend $8.2 million on advertising?

Ms Beauchamp: This was a decision of government.

Senator POLLEY: Can you confirm when the communications campaign started?

Dr Studdert: It started on 15 May.

Senator POLLEY: How long will that campaign run?

Ms Grinbergs: It will run for six weeks, until the end of June.

Senator POLLEY: Is that considered to be a good spend of money when there are 105,000 older Australians still waiting for home-care packages?

Ms Beauchamp: I think in the context of budget announcements around ageing—which wasn't just about aged-care packages; it covered a number of portfolios—it was about highlighting that we are all living longer and how do we prepare for that in the longer term? So this was really to support all of us taking responsibility for what we might need to do in terms of our financial future, our health future and the like. In terms of the total package, across government, the government decided to put that money into advertising, to bring this to the general population's attention.

Senator POLLEY: Has that money been allocated to television, print and social media?

Senator McKenzie: Yes. It has been allocated to a suite of media options to maximise its impact. The goal is not just to be targeting those towards the end of life but to actually start stimulating thinking about ageing and how am I going to prepare for a positive experience as I age, for people in their early 50s and beyond—so getting the finances sorted, making sure I'm physically active and starting to have those conversations with my family that I need to have.

Senator POLLEY: Is this the biggest advertising campaign out of this budget?

Ms Beauchamp: I think you would have to direct that to the Department of Finance.

Senator POLLEY: Do you anticipate that this advertising campaign could increase the long waiting lists for home care without having put in place the opportunity for people to be able to access the level of care that they need? So are you running a campaign getting people to be aware of what is available to them? We know there was a huge blowout in the three months' period where 20,000 additional people went on the waiting list. Isn't there a danger now there will be more people seeking home-care packages and there doesn't seem to be a budget for it?

Ms Beauchamp: I think it is probably useful to put it into context in terms of what has been happening in MYEFO. In MYEFO, there are 6,000 extra packages provided and, even in this, there is another 14,000.

Senator POLLEY: Over four years?

Ms Beauchamp: This is the biggest injection of aged-care packages for some time. Looking forward, I think those packages amount to 3,100 per year, is it?

Senator POLLEY: So that 14,000 packages over four years is not really going to address the 105,000 people, and many of them are looking for level 4 and level 3 funding.

Ms Beauchamp: I will let the officers talk about the people on the waiting list in terms of the support that they're already getting. I think, yes, there are some people looking for higher level packages, but in this budget I think the emphasis was on providing additional level 3 and 4 packages.

Senator POLLEY: Yes, I know, and I would be surprised if the minister at the table hasn't had her office inundated, as I and my colleagues have, with people who aren't getting any package—certainly, not getting the level of package that they need. When a 92-year-old gentleman is told that he will have to wait 18 months to two years for that level package, it's not very good as a politician to have to try to respond to that. So I just want to put it in the context of what is happening in the community.

Ms Beauchamp: I don't know about the particular case you mention, but some supports would be put in place whether it is through the Commonwealth Home Support Program or a lower level package.

Senator POLLEY: I just want to be very clear: 3,100 packages per year, over the next four years—is that the correct figure?

Dr Studdert: No, I don't think so. But let me get my colleague—

Senator POLLEY: In terms of packages that are additional to what was planned for.

Dr Studdert: The budget measure that puts funding in the system for an additional 14,000 packages—those packages will go out over the next 12 months. Is that correct?

Senator POLLEY: You're going to have 14,000 over the next 12 months?

Ms Buffinton: We expect to have an additional just over 8,000 packages going out over the next 12 months.

Senator POLLEY: Out of that 14,000?

Ms Buffinton: Yes. That is to make sure that we get the advantage in the system as early as possible—getting those packages making a difference. I think we have learnt a lot ourselves about the waiting list you have been referring to—the 104,000 people waiting at the 31 December. Of those 104,000, around about 50 per cent are on a lower level package. We think it's really important, so we acknowledge that there is a wait time for level 4 packages. But what's important is that around about 50 per cent are on lower level packages. Rather than people just referring to level 1, 2, 3 and 4, it's quite important that we start getting across what's actually involved in level 1, 2, 3 and 4. A level 1 package of $8,000 of support is around about $160 of support a week. A level 2 package of about $15,000 is around $300 of support a week. That's why we say people should accept an interim package, because it gets care into their home. A level 3 package of $33,000 a year is around about $650 a week of

care. A level 4 package of $50,000 is nearly $1,000 of support a week. So many citizens are thinking, as we have discussed before, that they should wait for this level 4, but we really strongly encourage them to take up level 2, if that's what they are being offered—level 1, level 2, level 3, level 4—where we upgrade them as the packages become available.

Senator POLLEY: The remaining 6,000 additional places, how long a period are they going to be rolled out? If you're doing 8,000 in the first year—

Ms Buffinton: The MYEFO packages were released before the end of last calendar year, before 31 December.

Senator POLLEY: Yes, but there are 14,000 additional packages out of this budget.

Ms Buffinton: Yes. So 6,000 plus 14,000, making a total of 20,000.

Senator POLLEY: Yes. When are you going to release the data for the waiting list? When is that due to be released?

Ms Buffinton: Typically, it has been at the end of a quarter, so we would expect it to be in early June.

Ms Beauchamp: Can I make a clarifying statement. I did mention 3,100. The government is releasing—on average, and currently—over 3,100 packages each week.

Senator POLLEY: Each week?

Ms Beauchamp: Yes.

Ms Buffinton: That, of course, does vary. We are constantly looking at the take-up so we don't have packages that don't have people in them. That varies from time to time—for example, we know that around Christmas time is not good because people find it difficult to take up packages. As the secretary says, since the beginning we have averaged a bit over 3,000 packages per week.

CHAIR: Senator Polley, did you have any follow-up questions?

Senator POLLEY: We started talking about home care, I wanted to do that but if you need to go to someone else, you can come back to me.

CHAIR: We will need to because there are so many senators who want to ask questions in this area. What is the number of home care packages available at the end of the forward estimates? What are we growing towards?

Dr Studdert: The number of packages in 2021-22 is expected to be 151,730.

CHAIR: Thank you.

Ms Buffinton: Compared with, say, 2017-18, which was 87,590. That's 87,590 up to 151,730.

Senator GRIFF: You would have a corresponding decline with residential, wouldn't you?

Dr Studdert: There's no recline in residential.

CHAIR: Senator Hinch.

Senator HINCH: Section 54-1 of the Aged Care Act outlines quality of care and talks about the responsibility of approved residential aged-care providers 'to maintain an adequate number of appropriately skilled staff'. In 2003, there were roughly 16,250 registered nurses employed in aged care and about 150,000 residents. By 2016, that had dropped to 14,500

nurses for an increase of nearly 100,000 residents, up to 235,000. The Australian Nursing & Midwifery Federation say the aged-care sector, therefore, has a chronic understaffing crisis. Does your department accept that?

Ms Beauchamp: I will ask the officers to respond specifically to those numbers.

Senator HINCH: The numbers have dropped so dramatically. I will give you an example. You well know that Victoria now has ratios in public nursing homes. I have an example here. In Castlemaine, at Mt Alexander Hospital, they must roster 10 nurses for their 153 aged-care residents. In Bupa Ballarat there are two nurses for 144 residents. That doesn't seem to me to be adequate care.

Ms Beauchamp: Just to clarify the act, the legislation requires aged-care homes to have appropriately skilled and qualified staff. It doesn't refer exactly to nurses.

Senator HINCH: No, I'm talking about staff as well. The figures I'm giving you are nurses, but the carers are complaining that they are being forced to work, for example, one overnight over three floors, things like that, which means they find it impossible to do their jobs. I'm talking about nurses and carers.

Dr Studdert: Right. But the figures you quoted—just to be clear—were for nurses only.

Senator HINCH: But I'm just wondering if the department accepts that there is a crisis in the number of people there?

Dr Studdert: I don't think we would be accepting that. We want to look at the workforce in a holistic way and also note that different services have different profiles of clients and different needs. Ms Laffan can give a bit more detail.

Ms Laffan: As you mentioned, the Aged Care Act requires each approved provider to have an adequate number of appropriately skilled staff to meet the needs of the care recipients at all times. That requirement is monitored by the quality agency. So there is not a set number or a specific ratio but there is a requirement.

Senator HINCH: I accept that, but the argument from the other side is, 'How do you determine what is adequate?', because what the department thinks is adequate may not be what the nurses and carers think is adequate.

Ms Laffan: The quality agency may able to speak to the elements that they look at in assessing that standard.

Mr Ryan: We assess under the existing standards, which, as you may be aware, will change next year. We assess under expected outcome 1.6, human resource management. That means that we require every provider to be able to show evidence of a comprehensive staffing approach. It does include having adequate numbers of properly skilled staff relative to the care needs of those residents. It includes things like how they recruit staff, whether they conduct adequate police checks et cetera. We monitor these very carefully. In fact, where we find failures against the standards that's one of the most frequent areas of failure. In relative terms, it is a small numbers of providers who fail, but, of the 44 outcomes, expected outcome 1.6 is an area that we pick up regularly in those homes that don't meet those outcomes.

Senator HINCH: Okay. It would seem to me to be a cost-cutting exercise by some of the private ones. There's a group called Japara Healthcare. They have now created a thing called 'Respecting Night Time for Residents—Etiquette Guidelines'. That means they have ordered

their staff not to check in on residents overnight, so to make sure they're breathing or haven't fallen out of bed, because 'it is not a valid reason to check'. Is anybody aware that that is going on in residential care?

Ms Laffan: We probably saw the same media article that you did about that. Checking on residents is a balancing act. Part of the standards require that we respect the care recipients' needs for natural sleep patterns and also personal dignity, but obviously that has to be balanced by their clinical care needs and whether they need to be woken or checked upon during the night. So it is a balance.

Dr Studdert: And that would presumably be tailored to each individual—

Senator HINCH: I know I haven't got much time, so I will be quick on a couple of things. When it comes to food, Bond University did a review recently of 800 care providers and they came out saying that the average spend per day per person is $6. Nurses have told me it's $6.08. I thought it was $6.30, but it's $6 a day. Last time I was in jail I got $65 a week, so more than $9 a day as a prisoner in Langi Kal Kal jail, and yet the average spend in these places is $6. Now something is rotten in the state of Denmark when that's the case, would you agree, Minister?

Senator McKenzie: I'll refer that to the Aged Care Quality Agency, because I think that our elderly need to be cared for in an appropriate manner.

Mr Ryan: Thank you, Minister. Senator, we take a particular interest in expected outcome 2.10, which is around nutrition, and expected outcome 4.8, which includes catering. We did see that research from Bond. I'm not here to comment on that particular research. We do conduct a thorough and comprehensive review of whether there is adequate hydration and nutrition provided to residents.

Senator HINCH: And quality of food, is that inspected as well?

Mr Ryan: Correct. In the last 12 months we have also been conducting consumer experience reports. We interview about 55,000 residents and their family members every year, and one of the first questions we ask is: do you get enough adequate food in this facility? The vast majority of residents and their family representatives say that they do. I don't have specific data on that across the country, but it is an area that our surveyors who go on site ask about. We interview 10 to 15 per cent of the residents. The interviewees are randomised choices. Food is the first or second question that we ask. If we pick up a trend with residents that they've got any concerns, we especially go to the management of the home and say, 'Evidence for us that you are meeting expected outcome 2.10 and expected outcome 4.8.' If we're unhappy with what they are able to evidence and if the residents show a high rate of unhappiness with the food, we will pursue the provider.

Senator HINCH: Can I close by going to homelessness. Last year, the Minister for Aged Care, Ken Wyatt, tabled a report on a legislated review of aged care. One of the recommendations was to find ways to further assist in better services for homeless people. I admit I'm involved with a group called Winteringham for homeless people aged over 50 in Melbourne. They provide most of their places to them. I'm wondering why on average for the homeless people, their payout is $40 a day less than the average basic subsidy amount? I know with—what's it called?—the homeless supplement that there's still a shortfall of $11 compared to the others, and I'm told that's going to go up to $19 by 2022. The question I ask

you is this: is there anything in the works to try to improve the homeless supplement or help out groups like Winteringham? Their occupancy level is something like 98 per cent, so they can't improve their financial performance through the greater utilisation of beds. Do you know if anything is in the works for that?

Senator McKenzie: That would be in the purview of the Department of Social Services, but we'll take it on notice and we'll check out with them what's going on.

Senator KENEALLY: It is not Social Services.

Senator POLLEY: It's aged care.

Senator SIEWERT: They run residential aged-care services.

Senator KENEALLY: This is residential aged.

Senator SIEWERT: We're talking about aged care here.

Senator McKenzie: The department can go to the sections that are relevant to us, but there are still aspects that will have to go to the other minister.

Senator HINCH: With homeless Australians considered to be a special needs group, they receive an average of $40 less than the average basic subsidy. It's been reduced by the homeless supplement and the viability supplement, but it's still short by $11. And that shortfall will increase by 19 bucks by 2022, and some of these places, like Winteringham, will not be able to stay open.

CHAIR: Just for clarity: the homeless supplement is run by the Department of Social Services.

Senator McKenzie: His questions were around the homeless supplement.

Senator SIEWERT: No, there is a homeless supplement for aged care. I know because I lobbied to get it!

Ms Beauchamp: Okay; it's good to clarify that.

Senator McKenzie: There are two supplements.

Senator SIEWERT: I got it in Living Longer Living Better.

Senator McKenzie: I apologise if I was thinking of the Department of Social Services.

CHAIR: And we've got the right people here?

Unidentified speaker: Yes, we've got the right people here and we can answer that.

Mr Murray: You've mentioned the homeless supplement, and there is a homeless supplement in aged care. The Department of Social Services also does provide some services to homeless people. In terms of aged care, it is correct that the average supplement under the aged-care funding instrument for homeless people is lower than the average supplement in general in aged care, but that is more reflective of the care needs of those people. The reason they are in care is not necessarily because of highly complex healthcare needs, which require a higher amount of funding; they're often in care because of their homelessness issues and so on. So while there is a lower amount there—

Senator HINCH: But why would they lower? If they're homeless—and I'm talking about older homeless people—their health is probably worse because they've come into care from being homeless under a bridge. The other thing is they have no family support; they can't sell

the family home to help out. There are very few bequests come into homeless people's abodes, so why would they get less?

Mr Murray: It is an assessment of their care needs. The way the funding works, every individual going into care is assessed. There is a whole bunch of questions under the aged-care funding instrument, which target their needs around activities of daily living, behaviour and complex health care. The basic subsidies are determined by their care needs, so every individual is assessed on their care needs. As a general rule, the subsidies have been lower for homeless people under ACFI, and that is a general reflection, and it will vary very much from resident to resident—

Senator HINCH: From what I'm hearing, it's the listed thing: homeless people are going to get less because they've been homeless.

Mr Murray: And there are specific initiatives where the government does pay higher supplements for homeless people. There is a homelessness supplement, which is paid to providers, to assist them in providing services to the homeless people.

Senator HINCH: Take this on notice: can someone provide me with what the breakdowns are of this, what the general amount is and whatnot?

Dr Studdert: Certainly, Senator. I also note, just to go back to Senator Polley's earlier questions, that it is being looked at further as part of a response to the Tune review. Recommendation 33 is to review further ways of assisting in the delivery of improved services to homeless people. But to clarify Mr Murray's point, if the health needs of any individual are such that they are requiring or deserving of a higher supplement, then they will get that. It's not based on their homelessness; it's based on their care needs.

Senator HINCH: But places like Winteringham only have homeless people; you don't get in there unless you're homeless, so they would all be in a different boat.

Mr Murray: They are all assessed based on their residential care needs. If they require a higher supplement, they will be paid that based on their care needs.

Senator HINCH: All right.

Senator SIEWERT: It seems like we will be jumping around a lot tonight. I want to go to this issue too, and I have a range of questions on the homelessness supplement. Mr Murray, when was the last time the department—sorry; it may not be you I direct the question to, but you're the person who's been dealing with this—did an assessment of the costs for residential providers who are particularly providing for homeless people?

Mr Murray: In terms of a review, I can't answer that specifically. There was an increase to the homeless supplement a few years ago. I'll have to check the exact details of when that happened.

Senator SIEWERT: Indexed or—

Mr Murray: Indexed, yes.

Senator SIEWERT: So that was an indexed increase?

Mr Murray: Yes. It's slightly complicated. There is a homeless supplement and there is a separate viability supplement, which also includes a component for homelessness. There was a reform measure a few years ago—I'd have to check the exact dates—which increased funding through that.

Senator SIEWERT: Through the viability supplement?

Mr Murray: Yes.

Senator SIEWERT: Can you perhaps take on notice to explain that—

Mr Murray: The exact details of that, certainly, yes.

Senator SIEWERT: because I'm not following how that relates to homelessness?

Mr Murray: Yes.

Senator SIEWERT: A lot of that viability supplement was about regional centres.

Mr Murray: That's a separate measure. There have been a number of changes in the viability supplement. Some were targeted to rural and remote. There was another one that was specifically targeted at the homelessness issue.

Senator SIEWERT: Thank you, if you could take that on notice.

Mr Murray: Yes.

Senator SIEWERT: Was that based on an assessment specifically of the costs associated with homelessness and residential aged care?

Mr Murray: I'd have to check the details as to exactly how that came about. I can take that on notice.

Senator SIEWERT: If you can take that on notice. I'd like to contest this issue about homeless people being less complex to care for. I've had quite a bit to do with this issue and I've visited centres that are specifically supporting homeless people, and there is a lot of complex care involved. On what basis do you make the comment that they are less complex?

Mr Murray: If there is complex care involved, they will be assessed as needing that complex care and that individual will get a higher—

Senator SIEWERT: This is where we get to what the definition of 'complex' is. It doesn't fit your typical ACFI analysis of complex is the point that providers who specialise in particular in providing residential care to homeless people—

Mr Murray: That is taken into account in the government paying this separate additional supplement for those people.

Senator SIEWERT: Yes, and the point being made is that that is not keeping up with the costs of providing that type of care. I go back to what my question was. You said two years when you reviewed it—

Mr Murray: I can't remember exactly when the change was made. It may have been three or more years. It was three to four years probably.

Senator SIEWERT: It would be really good to get nailed down when that assessment was done. This supplement only came in in Living Longer Living Better in 2013. If it's three or four years, that's actually the beginning of when your supplement came in—around that time.

Mr Murray: As I said, there are two different components to the supplement. There is the supplement and the viability expansion component, which is for homelessness. We can take that on notice and provide a detailed answer to that.

Senator SIEWERT: Okay. I'm aware that there have been a number of propositions put to you of the increasing costs in residential care for homelessness and there is a growing gap. Can you provide us with any assessment that you have done on the figures that I'm aware have been provided to you?

Mr Murray: As Dr Studdert mentioned, this was something that was raised in the Tune review and it is something that is under consideration by government.

Senator SIEWERT: Is it including those figures that I'm aware have been provided to you around the growing gap?

Dr Studdert: I'm sure we'll include all the available data that we have and, if we find gaps, then we'll be looking to address those. The Tune review was pretty clear on this issue—that there needs to be further work and review done. The department hasn't responded to that, but I guess we can indicate that we are certainly looking at that recommendation and it's the government's intention to respond accordingly.

Senator SIEWERT: When you were having a discussion earlier with Senator Polley—

Dr Studdert: About the Tune review, yes.

Senator SIEWERT: about the Tune review, you said that you're still considering those recommendations that hadn't been responded to.

Dr Studdert: Correct, and that would include recommendation 33 to review whether there are further ways—

Senator SIEWERT: Yes, I understand that. I took that from what you just said. Is the government now going to respond as a package on the rest of the recommendations or are you going to deal with them one by one? You can see where I'm heading with this. How soon will you respond to this particular recommendation?

Dr Studdert: It's impossible for us to commit the government, but our marching orders from Minister Wyatt are to get on with these pretty quickly. He has indicated to the sector that he intends to respond in due course, so I don't think it's going to be a long time.

Senator SIEWERT: Well, I've been doing this for quite a while now, and there's long and there's long.

Dr Studdert: I'm sorry; I can't be more specific than that.

Senator McKenzie: So you know that in due course—

Senator SIEWERT: That's even worse, 'in due course'! I know the language of estimates! Is it before the end of this year?

Senator McKenzie: Look, Senator Siewert—and Senator Polley gave it a good shake previously—it will be released in due course, knowing that Minister Wyatt has been working on and around the Tune review recommendations since prior to the budget and is continuing to do so.

Senator SIEWERT: Can I go back to the other part of the question, which was: are you planning to do the response as a final response on all the outstanding recommendations or are there some that you may announce sooner rather than later, or 'in due course'?

Ms Beauchamp: We are doing the work around the remaining recommendations now. How the government wants to announce that, whether it's a package, a response formally or

over the next few months, is really a matter for the minister and the government. We are doing the work around the remaining recommendations, of which this is one, but it really is a decision for the minister.

Senator SIEWERT: So what you're saying is: the decision actually hasn't been made yet? Is that a correct interpretation of what you just said—in terms of altogether or as they happen?

Ms Beauchamp: As I mentioned, we're doing some work to provide options and advice to the minister. Sorry, Senator; that's—

Senator SIEWERT: In other words, the decision hasn't been made, or are you telling me it has been made about that and you're just not telling me?

Dr Studdert: There's been no decision made.

Senator SIEWERT: Thank you. That's all I asked.

Dr Studdert: We need to give advice to the minister on the remaining recommendations.

Senator KENEALLY: On a similar topic—and I'll be interested in your answers to Senator Hinch on notice; they reflect a number of questions I'm also interested in—in this same vein about aged homeless people I'd like to talk about prematurely aged homeless people and the aged-care assessment service. Previously the aged-care assessment service was able to provide support for prematurely aged homeless people with a disability before they turned 65. Is that correct?

Dr Studdert: I believe so. I'll just get the relevant officer.

Mr Murray: Are you referring to young people in residential aged-care facilities?

Senator KENEALLY: I am referring to prematurely aged homeless people—people who are homeless, classified as prematurely aged. They used to be able to receive aged-care services but now, if they have a disability, my understanding is they are being told to apply first to the National Disability Insurance Scheme rather than go through the aged-care assessment service.

Ms Buffinton: As far as the interface with disability, first in aged care we do recognise that people who've faced homelessness do suffer from premature ageing, and so we run a program of assistance with care and housing as part of the aged-care program. The group is for prematurely aged people who are aged 50 years and over or 45 years and over for Aboriginal and Torres Strait Islander people who are on low income and who are homeless or at risk of homelessness as a result of experiencing housing stress or not having secure accommodation. We can undertake an assessment and we can offer support. Part of that support, which comes in under our Commonwealth Home Support Program, is that we offer coordinating and linking support for the clients to coordinate a multi-service response to secure housing and interact with a multitude of services. If need be, we also provide translation and then, once that housing is secured, we give them the support in their accommodation.

Senator KENEALLY: Before the National Disability Insurance Scheme came into effect, if that person had a disability and they had been assessed to be prematurely aged homeless people, would you also have looked to provide support for the disability?

Ms Buffinton: Certainly, under the age of 65, where somebody has the potential to be assessed for the NDIS or, in this case, a premature ageing package, what we would seek to put

in place is what is most advantageous to the individual depending on their circumstance. It may well be that the NDIS may offer that in that situation, depending on the circumstance.

Senator KENEALLY: Is there an actual protocol around this? From what I'm hearing from service providers, there may be an unintentional gap here, that people who don't neatly fit into one category or the other may be getting different types of advice or being told they should go apply to the NDIS, even though they may have little chance of receiving support through the NDIS. They might not meet the right threshold, or they might wait a very long time to get a plan, if they get one. It seems that there is this gap with these people. I'm trying to understand whether you've got a protocol to deal with them, or if there is more work that needs to be done, for the people—a small number of people to be sure—who fit in this fairly defined category.

Ms Buffinton: Certainly that's something I will take up. Obviously, with a very new scheme like the NDIS, all of us are trying really hard to make sure people genuinely don't fall between the cracks. I will certainly take that particular issue on notice and talk with our colleagues at the National Disability Insurance Agency.

Senator KENEALLY: As I said, I think this is potentially an unintended consequence, but I do think there is a real issue occurring for service providers who are not able to get their clients the services that are needed because they can't get them into the NDIS, but they're being told through the Aged Care Assessment Service that's where those people need to go, and they don't necessarily fit.

Dr Studdert: As Ms Buffinton said, we are quite acutely aware of the interface issues and working very closely with our colleagues at NDIA to work through these as the scheme comes into implementation.

Senator KENEALLY: Could I also put on notice to ask whether there has been any consideration or could be consideration of some type of transition process for prematurely aged Australians who are homeless and have a disability to continue access support via My Aged Care either while they're waiting for NDIS or until there is a determination.

Dr Studdert: These are exactly the issues we are working through at the present, but we can certainly get you more information on that particular one.

Senator POLLEY: On Wintringham services, can you tell me how much Wintringham receive annually in funding from aged care?

Dr Studdert: I may be wrong, but it may be unlikely we have a specific number for that specific service. We can certainly take that on notice and give you the information.

Senator POLLEY: Can you take that on notice? I'd be interested in knowing whether or not that annual amount has decreased over recent years. Could you take that on notice for me? If it has been decreasing, which you can't answer at the moment, there is a real risk that these people that currently are housed there won't have any services to them. If you can take it on notice and let us know, that would be great. Just before I hand over, there are two things. The figures that the department officers referred to, David Tune's report, can we have that document tabled, please, for the committee?

Dr Studdert: I think it's publicly available on our website but we can certainly table it.

Senator POLLEY: And the quarterly data figures for the waiting list for home care packages—who makes the decision about when that will be made public?

Dr Studdert: We provide the data and the advice to the minister and then it's the minister's.

Senator POLLEY: For instance, you are saying it should come out in the beginning of June, but you would have already given that advice to them?

Dr Studdert: I'd have to check on that, but it really reflects when we have the data ready and how quickly we can do that.

Senator POLLEY: Could you take on notice as to when the figures were available before coming out in June, that tidies up that bit.

Senator GRIFF: I have a few questions regarding the voluntary National Aged Care Quality Indicator Program. According to information provided on notice to me from the February estimates, only nine per cent of providers participate in the program. How many providers is that in real numbers?

Ms Jolly: That's correct. It is over nine per cent. It is 245 in the quarter ending 31 March 2018.

Senator GRIFF: How many providers are there all up? I can do the calculation.

Ms Jolly: That represents around nine per cent, so we can reverse engineer.

Senator GRIFF: This isn't mandatory, is it? This is just a voluntary reporting?

Ms Laffan: That's correct.

Senator GRIFF: Is there any prospect for the program to become mandatory? I imagine that's something you would like to see happen?

Ms Jolly: That was one of the recommendations of Carnell Paterson. Currently COTA have been doing some work and analysis of the program and of the barriers to take-up in the program. That's currently being considered and we'll be providing further advice to government about how they might respond to some of those barriers in that context.

Senator GRIFF: Is there any incentive offered to people to participate in the program at this stage, to provide the data?

Ms Laffan: One of the incentives is that the provider's participation in the quality indicator program is identified on the My Aged Care website. The provider can say, 'Yes, I'm participating in the quality improvement exercise.' The incentive is also on continuous improvement. They receive reports that compare them to other providers who also participate in the program, so they're able to look at how they're tracking and assist in their quality improvement on those measures.

Senator GRIFF: Would the providers that are giving you this information voluntarily be considered to be, if you like, the top or the best aged care providers?

Ms Laffan: I couldn't possibly answer that.

Senator GRIFF: I would imagine there would be a number that would not want to provide you with the information because it may be a little negative to the way they're operating.

Ms Jolly: The way I understand the system is that there are a set of indicators that some systems and some providers are able to provide information into, and that's an easy process for them to do that. A vast majority of those who are participating in the program have that easy sort of uptake of their own information. There are other providers that have their own indicators that they would be monitoring for their own services. I didn't want to give the impression that these are the only indicators that services are monitoring. These are the three in the program that we have.

Ms Laffan: There are commercially available products out there which have a wider range of indicators, so some providers might be using those indicators. They might be using our program and other indicators, or our program.

Senator GRIFF: But you don't have visibility to the other programs, though? They're only sending you—

Ms Laffan: No, we don't receive that data.

Senator GRIFF: I imagine you are focusing on those three quality indicators that were in the initial pilot as well. So you don't have plans to add falls, malnutrition and the like? You don't have plans to increase or go past those three?

Ms Jolly: There has been some analysis of the program overall and we are in the process of providing that advice to government. Some of the questions you raised will be considered in that context.

Senator GRIFF: I'd like to turn to some questions I asked in February in relation to the return of funds from people who passed away who had home care package funds. How many providers are actually receiving funds on behalf of people that have qualified for levels 1 to 4? How many providers are there that are actually in receipt of funds?

Ms Buffinton: There are 806 approved providers. I might just have to check with a colleague on the number who are actually receiving funds, because somebody who is new and now approved doesn't mean they have yet taken on any clients. So I might have to take that on notice in respect of the exact number. It'll be something less than that number of 806 who are currently getting a flow.

Senator GRIFF: How many providers in the last 12 months—it can be any period that you want to take, the last financial year or any 12-month period that you wish to choose—have actually returned unspent home care package funds?

Ms Buffinton: As at 18 May there had been $76.5 million in returned unspent funds. I'm just looking to see if I've got the number from how many providers.

Senator GRIFF: That's a 12-month period? That's a rolling 12 months?

Ms Buffinton: That was from 27 February, when we started with increasing choice. We officially started the new increasing choice measure on 27 February 2017.

Senator GRIFF: So from 27 February to 18 May there was $76.5 million returned.

Ms Buffinton: Sorry, I'll correct. As at 18 May, that's how much funds have been returned for the period 27 February to 31 December. That's the calculation, but it may have been after 31 December that the funds were actually returned.

Senator GRIFF: That would equate also, having a look at the answer to my February question on notice, where I think it said unspent funds on average were $4,383 per recipient

who had left care. In another answer to a question on notice, you stated that no compliance action had been taken against providers in relation to unspent funds. So there was no auditing—that also came out in February as well. Have you undertaken any auditing since I asked that question in February? Is there any audit program in place?

Ms Mond: The department is trialling a risk profiling approach. We'll be targeting a small group of home care providers through a pilot audit program and this analysis will draw on data collected from the Department of Human Services through provider self-reporting. That includes reporting on unspent funds. The outcomes from this pilot will be available in the second half of this calendar year and will inform the future development of the home care compliance program as we build the model towards a single quality framework and the establishment of the new Aged Care Quality and Safety Commission.

Senator GRIFF: That's very good to hear. Thank you.

Senator SIEWERT: I want to go back to residential funding and the Stewart Brown December 2017 report. It indicates that 41 per cent of residential-care providers have reported an EBITDA loss. Have you considered the information that's in that report?

Mr Murray: Yes, we are aware of that report.

Senator SIEWERT: How much has it gone into your thinking over residential care?

Mr Murray: We constantly monitor what is happening in the sector. We look at the Stewart Brown reports when they come out every quarter. As you'd be aware, the Aged Care Financing Authority also produces an annual report on the sector, and all those issues are monitored and considered.

Senator SIEWERT: Yes. You pre-empted my next question. When do you expect the next report of the financing authority?

Mr Murray: That's due at the end of June.

Senator SIEWERT: So it'll be presented at the end of June?

Mr Murray: That's when it's due.

Senator SIEWERT: It's 2017-18. Is there not normally a lag time after the end of the financial year?

Mr Murray: Yes. The ACFA report that will be released in June will cover results from the last financial year to June 2017. The annual returns are lodged in October 2017.

Senator McKenzie: There's quite a lag.

Senator SIEWERT: Outside of the financing authority, have you given consideration to the fact that 41 per cent of residential-care providers are reporting that loss instead of just waiting? I understand the point about the finance authority but, given they're reporting on the previous financial year, this indicates, perhaps, a problem. How are you responding?

Mr Murray: It's probably useful to understand some context of those figures. Providers do report losses from time to time. That doesn't necessarily mean that they're not an ongoing operational concern. It's also relevant to note that, as you would be aware, last year—or the current year—there was a pause of the ACFI subsidies, so indexation was not applied. That has an impact on their results for that particular year. But indexation in the main returns from 1 July 2018, so funding will again increase from 1 July 2018 for subsidies. I guess that year

we're talking about has been impacted by the freeze in ACFI indexation subsidies for that year, but from next year indexation returns. All the numbers need to be considered in that sort of context.

On the broader issue of funding for the sector, as you would also be aware, the government is examining reform to their long-term residential-care funding-reform arrangements. The University of Wollongong has been commissioned to undertake work and is currently undertaking a detailed resource and utilisation classification and costing type study of the sector. The government is very keen to get this evidence base of information on what is happening, in cost, in the sector and that will inform their long-term deliberations around funding reform.

Senator SIEWERT: I take your point around indexation but have you tested that theory, as you've just articulated, with the financing authority?

Mr Murray: The financing authority is an independent board. They consider things—

Senator SIEWERT: I mean have you asked them or spoken to them about it.

Mr Murray: They're aware of it. They're certainly aware of those results and they consider those results at their meetings on a regular basis. It's also worth noting that indexation was paused back in 2012 and there was a drop-off in financial performance in that year as well. Subsequent to that, the results improved. Again, we need to wait and see how things settle on some of these issues and look at the long-term funding work that the University of Wollongong is doing, and the costing studies, to get a better feel for what might need to be done in future on funding reform.

Senator SIEWERT: Can you remind me when the University of Wollongong report is due?

Mr Murray: Their study is being done through the course of this year, so their costing-study aspects will be finalised by the end of the year.

Senator SIEWERT: Just on that: given that it's only small—I think the Stewart Brown study only looked at about 13 per cent of providers—do you consider that the 41 per cent figure is representative, or do you have—

Mr Murray: The figure in that last ACFA annual report was about 35-ish per cent, and that's been fairly constant. The Stewart Brown survey is based mainly on the not-for-profit sector, so it is slightly skewed towards the not-for-profit sector. Generally, the for-profit sector has slightly better results than the not-for-profit sector.

Senator SIEWERT: Sorry, so, the for-profit sector has—

Mr Murray: The for-profit sector generally outperforms the not-for-profit sector and the Stewart Brown report is based primarily, not fully, on the not-for-profit sector.

Senator SIEWERT: Yes, thank you. Can I go back to the plan to combine home care and residential care? In terms of the funding now being one program. Can you just explain how that's going to work?

Dr Studdert: So, how will it work?

Senator SIEWERT: What changes are you planning for the operation of both residential and home care now that it's going into one fund, or one approach?

Dr Studdert: I think the intention is to give flexibility in the way government can move forward in funding the mix of services, whether they be residential or home care, noting that the demand is shifting over time and that this enables the funds to be reallocated and redistributed according to where there's greater growth in demand. And where there's slowing in demand, obviously, there's no reduction in any funding line; it's all growth. It's just that where we've projected and tried to model what that growth will be, sometimes we get it slightly off, and so we can adjust accordingly, year on year. Obviously, that will be done in consultation with government and decisions around policy settings. But that is the intent of the adjustments to and combination of the two programs.

Senator SIEWERT: We've had this long discussion around the 20,000 additional places, the 6,000 and the 14,000. Into the future, is that then going to be a decision of government in terms of the number of packages that are allocated to home care, for example? If we've now got one fund, do you then foresee that into the future demand will determine how many home care packages there are and how many residential packages there are? Is that the intent?

Dr Studdert: So—

Senator SIEWERT: If you've got one fund, then surely you go with the idea of being flexible to meet where care is going. Is that what you see happening, or will you always have this divide, this allocation of—

Dr Studdert: Well, decisions also have to be made, year on year, as to what the growth settings will be. That will respond to where there's greater demand. There's always greater demand—just to reiterate that point—but it's just whether the growth has been as great as has been predicted. But the clear intent is to capture that money in aged care and to make sure it's being allocated to where there are service needs and demand in the system.

Mr Smith: If I can add it that? It's important to note that the residential care program remains demand driven, so that anyone who's been assessed for residential care and requires a place would have access to a place. It's only where a place is unoccupied and creates funds that would have otherwise have been lost, had this new program not been created, that then becomes available for a decision for allocation across to home care.

Senator SIEWERT: In terms of flexibility, I understand the point: flexibility is that what's not used in residential care goes into home care.

Dr Studdert: That's the intention. It's the flexibility, exactly.

Senator SIEWERT: My point still stands, in a way: why then allocate places for home care now that you've got the initial settings there? Surely, if the demand for residential care is not there, the money will flow into the home care packages. So there could well be more than—

Let's use the 14,000 for the time being. That's an estimate. Are you saying that, in fact, there could be more home care packages available if the money is there, regardless of how much money the government has allocated?

Dr Studdert: Regardless of how much the government has allocated?

Senator SIEWERT: The government said 14,000. Right?

Dr Studdert: I think there has to be a process by which government looks at the settings and makes those decisions. I think they've been quite clear that the intention is that the money

is available for re-allocation if there's underutilisation of funding in either sector. In the current terms, it's more likely to be in the residential.

Senator SIEWERT: If this is going to be truly flexible and responsive, then surely the decision is whether it goes to one, two, three, four, not whether there is a package there? If this is a flexible fund and the money is staying in there, why would that not happen?

Mr Smith: Senator, we need to have a look at what is happening in demand over time. An assessment would be made not based on the fact that a dollar is available today and, therefore, it flows to home care packages. It's that from what we are seeing in the trend in demand, based on the modelling, we expect over the next period of time this is the number of unoccupied places, the unused residential funding, that would become available for new funding in home care.

Senator SIEWERT: I take your point. Surely, you will be able to make those decisions more quickly, because they are staying in care for a shorter time.

Dr Studdert: There are a whole lot of variabilities that play into the underutilisation of residential funding. Yes, the stay time is part of that, and the lag times in uptake that can occur. So there are a range of variabilities. We are able to get visibility of the underutilised funds as the year rolls on. Then there are options for government as to how those funds are reallocated or redistributed to, most likely, home care packages and what the allocation across the different levels would be.

Senator SIEWERT: Where else would it be allocated if it weren't to home care packages?

Dr Studdert: I think those are the two major areas.

Mr Murray: Senator, just to add to that. We estimate demand based on age-specific usage rates and demographic factors in residential care and home care. We continue to do that, and planning ratios continue to guide the long-term direction. We accept there is going to be growth in demand across all programs as the population ages. That's all built into the estimates. What this program allows is that, if it turns out there is more of a swing towards home care than we might have predicted and that has been conversely seen in the reduction in residential care demand, we will be able to use that unused funding on residential care to move it to home care where people are more interested in having care delivered in their home, if that is how the trends move in future.

Senator SIEWERT: You have allocated 20,000 now. We have also had a discussion about how that's not meeting the demand for home care. What's the next stage here in terms of the approach to address the 100,000 people who are still on the waiting list?

Dr Studdert: It's a process that will continue to be monitored very closely by the government and the department with the data that become available quarter by quarter. As Ms Buffinton explained earlier, the people waiting is a very dynamic situation. People are moving in and out of different care needs. They're moving into residential from that assessment. So, it is a dynamic situation and we continue to monitor that and provide advice to government, and those decisions are made as funds are realised and available to be allocated.

Ms Buffinton: Can I make some comments on what we have come to understand. For over 12 months now, we have got this group waiting—so, the 104,000 as at 31 December. As we have discussed previously, for 27 February last year, there was a queue and wait time but

it was at individual providers, so we didn't have view of that. Of the 104,000, first of all, as we've discussed, we know that some are taking interim packages—about half are in interim packages, about a quarter are in Commonwealth Home Support and a quarter may be choosing at the moment not to take care but are wanting to stay on the wait list until they get the higher level of the package. The other thing we have learnt about the 104,000 is that when an ACAT does an assessment of a more-frail person with more-complex needs—typically somebody who would get a Home Care Package at level 3 or 4—they are also assessed for residential care. So, typically, that person would get an assessment saying that they are assessed for, say, Home Care level 4 and they are also assessed for residential. They join the queue of 104,000, because at that point the ACAT, and often the individual, don't know—they may aspire to want to stay in their home, or they may not. But they are given both assessments. Just so we are clear: 104,000 will not automatically all flow into Home Care. That is really important because a large number of those effectively will—

Senator SIEWERT: End up in residential care.

Ms Buffinton: Yes. I don't mean by 'end up' that they will choose residential care—

Senator SIEWERT: I meant end up choosing residential care—

Ms Buffinton: We have had many a debate. Some have asked, therefore, why you would say there are 104,000. I'm a purist: they are on the queue for either—half of them are already in Home Care but they are still not at their final level of package. But we also know that many of them, because they have that dual assessment, will choose residential care. I think that's important—

CHAIR: Last question, Senator Siewert—for now.

Senator SIEWERT: I understand what you are saying. Some of the '104' have been there for a while. Would they not have chosen residential care by now, if they are really frail—

Dr Studdert: I just think it is very hard to generalise about any particular scenario, because people's situation changes. Sometimes they are with family members—it's a dynamic situation and when a particular level of package comes up they may opt not to take it, but they can come back later and take it. So, as Fiona has described, it is quite a dynamic situation and it is hard to characterise any particular scenario.

Senator SIEWERT: When do you take them off the list once they have gone into residential care? What line of sight do you have for that—off the home care list?

Ms Buffinton: When a residential provider brings somebody on as one of their clients, then, through the Department of Human Services, they notify so that they can start being paid for that individual. That's where the computer dynamics do a reconciliation and then they come off the Home Care queue.

Senator SIEWERT: Are you able to tell us how many people that's happened to?

Ms Buffinton: I'm happy to take it on notice, because we are also interested. As you can imagine, each quarter we learn more about the data, because it is new data for us as well. Like you we are interested in seeing, if we take a period, where the shifts are occurring, so that we can start predicting the likelihood of demand for residential versus home care.

Senator POLLEY: When we refer to the data that gives us the figures for the waiting list for Home Care Packages, if the last figures you have been using are December's, the next

quarter would be March and we still haven't got them—and we're at the end of May. Who makes the decision about whether they are going to be released? Is that Minister Hunt or Minister Wyatt?

Dr Studdert: The advice is provided to Minister Wyatt.

Senator POLLEY: If the quarter finishes at the end of March, why are we still waiting? Can't there be a set date after each quarter so that everyone knows you would be able to release them a week or two weeks after that?

Dr Studdert: As we described earlier, it takes a while to pull that data together, to get the report into order, to validate it and to ensure it is in accurate and reportable form. On average, it's been taking about six to eight weeks to do that. I don't think there's anything unusual—that's been fairly consistent over the—

Ms Buffinton: Clearly, because it is a market place and people are very much reliant on that data, we've been very careful in making sure that we have done all our reconciliations with Human Services with My Aged Care and so forth to make sure that the data's correct.

Senator POLLEY: So you cannot release any information from the last quarter? You would have all that there, and you're anticipating—

Dr Studdert: As I think we said, we're in the process of finalising that and providing it to the minister. But, just to be clear, it doesn't in any way affect the operation of the system and the movement of people into receiving care packages. That's a dynamic situation every day. There's a point in time—

Senator POLLEY: But the release of that can be manipulated for political reasons, though. Can I move on to home care packages. Could you explain to us how the 14,000 home care packages included in the budget were funded? I got the indication, from answers in response to Senator Siewert, that there's flexibility now and that you can take the money out of residential care that's not being used? Is that a fair assessment?

Dr Studdert: Just to be very clear: it's not being taken out of residential care. There is growth built into the funding over the forwards. Some of that projection and modelling is not exactly accurate, so some of the money that has not been taken up and used in residential has now been made available and reallocated to provide a significant growth in home care packages.

Senator POLLEY: So, you can confirm, then, that 14,000 home care packages were funded entirely by a reduction of more than 20,000 in projected residential care places between 2017 and 2020?

Dr Studdert: I don't think I gave you that number.

Senator POLLEY: No, I'm asking you: is that the number?

Dr Studdert: I don't have that number.

Senator POLLEY: Can you take that on notice for us, please?

Dr Studdert: I can take that on notice, but—

Ms Beauchamp: I think we can confirm—

Senator KENEALLY: I'm trying to understand this as well. It seems to me that the answer was that when there is an unexpected lack of take-up—for want of a better term—in

residential that you're now able to use some of that money for home care packages? Is that what has happened? That, if there is a shortfall in your projected residential places—

Dr Studdert: The growth in take-up of residential care places.

Senator KENEALLY: Yes. So, there's a shortfall that's allowed you to invest into these home care packages?

Dr Studdert: The growth has not been as great as previously projected and modelled in the budget.

Senator KENEALLY: So, what was anticipated and what is the shortfall? When you say the growth has not been as great, can you quantify that?

Dr Studdert: I don't have that number, but—

Senator KENEALLY: But it must exist for you to be able to say—

Dr Studdert: I don't think you can equate it to any particular number of packages or places, because everyone's costs and places vary.

Senator POLLEY: Yes, we realise that. But you must have a figure that you've been able to manipulate over into home care packages.

Senator KENEALLY: There must be a figure to work with. How did you decide whether to invest in the 14,000 home care packages?

Mr Smith: Senator, the figure is $1.6 billion in unused residential funding—that is, funding that would not have been available to the aged care sector or the residential care sector. By bringing the two programs, the home care and the residential care programs, together, that funding has been ringfenced and has been able to support other funding in aged care.

Senator POLLEY: That's very helpful.

Senator DEAN SMITH: That is different from previous governments' approaches, though, isn't it?

Mr Smith: It's a structural change to the way the program's funded.

Senator POLLEY: Excuse me, can I—

CHAIR: Sorry—government senators are being very generous with their time. We are allowed to come in with a supplementary question.

Senator KENEALLY: And we waited patiently while Senator Siewert asked her questions. Now—

CHAIR: The last time I looked Senator Siewert wasn't a government senator. Senator Smith, you have the call for a supplementary question.

Senator KENEALLY: My point is: Senator Polley has the floor.

CHAIR: No. Senator Smith has asked for a supplementary question.

Senator McKenzie: I think the chair gets to determine that.

Senator DEAN SMITH: We canvassed this issue yesterday when Senator Keneally was not here and when Senator Polley was not here. There's a fundamental difference in approach here—

Senator POLLEY: We know that.

Senator DEAN SMITH: where, if I understand your evidence, the money is being reinvested into aged care. In previous budget measures, without drawing too fine a point, under the previous Labor government, that money was lost to aged care.

Mr Smith: Senator, there has been a structural change to the way the programs have been delivered; the structural change is to bring together the home care and residential care funding. Had that not occurred, then unused residential care funding is lost. It is returned to consolidated revenue.

Senator Dean Smith: That's right. And in previous budgets it was lost.

Ms Beauchamp: Yes.

Senator POLLEY: We all know that.

Senator Dean Smith: No, you don't, because you weren't here yesterday, Senator Polley.

Senator POLLEY: I do know that. That's not the question. What modelling was done to calculate the 14,000 home care packages included in the 2018-19 budget? What was the modelling done to come up with that figure of 14,000?

Ms Beauchamp: There was a lot of work done as part of the budget process, and we are not in a position to provide information in relation to that modelling, Senator.

Senator POLLEY: So you have done modelling but you are not prepared to advise us of what that modelling was?

Ms Beauchamp: No; that was for budget deliberations.

Senator POLLEY: Then can you confirm whether all of the 14,000 home care packages are high-level, and how will they be allocated across the four years?

Dr Studdert: It's been quite clear that the money is to be allocated to level 3 and 4 packages; so, yes, the high-level packages. And I think, as we described earlier, that funding will flow into the system over the next 12—just over 12—months. It's intended that 8,000 will be released over the next 12 months, and then into the next financial year.

Senator POLLEY: And the remainder over the second year. Can you please give us a breakdown of the number of level 3 and the number of level 4 packages that are going to be part of this new allocation? How many have been identified as level 3, and how many have been identified as level 4?

Dr Studdert: We can take that on notice.

Senator POLLEY: So you have done all this modelling, but you can't tell us what the breakdown is.

Dr Studdert: Well, I think there is some view that we need to have some flexibility, so we are responding to where there is demand and—as I've been trying to paint the picture—

Senator POLLEY: There is a lot of demand in Tasmania, and that's only one state. If you look around the country, that's not very many additional places.

Dr Studdert: It is 14,000 additional places.

Senator POLLEY: Yes. But in the last six months, is it not correct that there were 20,000 new people entering onto the waiting list? That was in six months.

Dr Studdert: Senator, I think you have the data that was reported for 31 December.

Senator POLLEY: Are you confident that 14,000 additional places is going to be enough to meet the current demand?

Dr Studdert: Senator, we are aware of the numbers and, as we have discussed, it's a very dynamic picture. There is definitely a lot of demand out there to continue to be worked on, and we continue to track that very closely, work with the sector to understand where there is growth and where there is unmet demand, and respond accordingly, with the budget and resources that we have.

Senator POLLEY: Okay. Do you have any indication on a state by state basis? What allocation is going to each state?

Ms Buffinton: Just as a reminder, the major change of 27 February last year was that we used to provide—through the aged care allocation rounds, the ACAR rounds, we used to give providers—and therefore in states—certain allocations. That concept stopped on 27 February; now we assess individuals and so it doesn't matter geographically where you are, it is up to when you had your assessment—the date of your assessment—and the priority of your assessment. So it is the level, the date of your assessment, and your priority that decide when you as an individual get the package. The concept of being allocated to states or allocated to providers doesn't exist any more.

Senator POLLEY: So for those people that have been waiting already for 18 months to two years, would they be the priority then, if they need a level 3 and 4?

Ms Buffinton: There are two elements: there is level 1, 2, 3 and 4—that's what an ACAT assesses; then they do an assessment on priority, and that takes into consideration a range of things, including: does the person live alone, do they have family support, or an active partner?

It doesn't mean that level 4 will always be high priority. It could be at level 2, your high priority, because you have no alternative but to get care immediately. They're the two elements: your level, 1, 2, 3 or 4; and your priority, medium or high.

Senator POLLEY: The sector is telling me that there isn't the same amount of uptake of level 1 and level 2, that the crisis is in level 3 and level 4. If that's the case—even if we go by your figures, which I think are much higher than 50 per cent—50 per cent of people are waiting for levels 3 and 4. Some of those don't have family around. The 14,000 places that the government has brought down through this budget aren't enough.

Ms Buffinton: First of all, we need to get across the concept of—when we say a package is available, it's a package available for the whole year. We know that the median time people are in home care—people are quite surprised by this—is 12 months, because home care, unlike Commonwealth home support, does kick in when people are at the frail end of life. We know, just by the numbers we have flowing in each quarter and flowing out, just as a reminder, for the September quarter—the last data package—we had 11,200 new entries, 8,500 exits, and, as we acknowledged, an additional nearly 4,000 packages overall. So people are flowing in each quarter and flowing out. They're either going onto residential or passing away.

Senator POLLEY: Waiting.

Ms Buffinton: No, these are ones who are in packages. I'm talking about the people who are getting allocated packages. Across the 12 months, sometimes two or three people may use

one package. I don't want you to think that one package equals one person; sometimes one package might have two or three people in it in the course of a year.

Senator POLLEY: So are you confident that this allocation of 14,000 new places, with a waiting list of 104,000 to 105,000, is going to address the shortfall?

Ms Buffinton: It's an investment being made by the government. As we've discussed, prior to February nobody really understood the nature of demand and the queue. We know that people are keen to stay in their homes, relative to residential. There were ratios that were put together under Living Longer Living Better, which made a certain set of assumptions. We know that, here in 2018, people are substituting home care for residential care at a higher rate than was expected. The government has made the investment that they have.

You were asking about growth. Straight after we started with home care there was a very high profile of home care, as we'd had a lot of advertising about the changes to home care. From February through to the end of the year, we had a rapid growth in that queue. We started to have a real queue. That has now slowed down. We saw in that final quarter that it grew by just under 4,000 people.

Senator POLLEY: Is your expectation, when this data comes out for the last quarter, that it will be significantly less?

Dr Studdert: I don't think we should speculate.

Ms Buffinton: I'm not speculating on that. I'm talking about the final quarter at the back end, to 31 December—the data that we're discussing.

Ms Beauchamp: Combined with increases already planned, I think the bottom line—

Senator POLLEY: Sorry, I can't hear you.

Ms Beauchamp: For the bottom-line figure over the forward estimates, I think there are going to be more than 74,000 high-level—3 and 4—home-care packages available, which is an increase of 86 per cent on top of 2017-18 levels. That's quite a significant growth for the level 3 and 4 packages that you're talking about.

Senator POLLEY: Can we move on, then, to get some figures in relation to the forward estimates? Can you break down the level of packages that are going to be available over the forward estimates? I don't know whether you need to take this on notice.

Ms Buffinton: This is effectively what we discussed a little bit earlier.

Ms Beauchamp: I think you spoke about the global figures over the forward estimates and that we would take on notice the breakdown.

Senator POLLEY: Can you give us a breakdown of the people who are currently on the list? How many people are waiting for each of their levels: one, two, three and four?

Ms Buffinton: That's in the data report that we report on each quarter, but we'll provide it as well.

Senator POLLEY: Thank you.

CHAIR: Senator, that's 15 minutes. Senator Keneally can have the call if she desires or you can cede it to Senator Polley.

Senator KENEALLY: She's on a roll. I'm happy to cede to Senator Polley.

Senator POLLEY: How many people do you expect are going to be on the waiting list by the end of the forward estimates?

Ms Beauchamp: We really can't speculate, Senator.

Senator POLLEY: So you don't feel confident that what you've recommended to the minister is going to be able to address and reduce this waiting list significantly?

Ms Beauchamp: It's not a matter of being confident. I think Dr Studdert spoke about how dynamic the waiting list is, the impact and getting a good handle on some of the reasons for the changes in the waiting list. I don't think we should speculate on what might happen in the future.

Senator POLLEY: In relation to home-care packages, the Minister for Aged Care was quoted as saying:

It'll be the status quo for a short period of time and then we'll start to look at a range of other interventions that will reduce that list.

Can you explain to me the status quo he was referring to? What does that actually mean?

Dr Studdert: I wouldn't want to interpret the minister—

Senator POLLEY: Perhaps the minister can answer it?

Dr Studdert: but the government's made a budget announcement and we've got to now implement that and work with the sector to see what impact that has. I really want to emphasise that it's a very dynamic situation. We learn more and more each iteration of this process. It is a relatively new concept still—that we're managing this list. I think the minister would like us to implement this, collect data and give the government further advice on what the impact is having, what we learn out of that and where the further attention is needed.

Senator POLLEY: Can you explain to me what he was referring to with 'other interventions'?

Dr Studdert: Again, I don't want to extrapolate too far, but I think the government has a comprehensive package for ageing which goes to a range of issues around healthy ageing and planning for ageing, all of which I assume we're doing to impact on the quality of ageing, the amount of care and the services that are needed as people get to those later stages.

Senator POLLEY: At the last round of estimates, there was a question put on notice—SQ18-000359—relating to unmet demand. The question was unanswered before the budget, but the rationale given by the department was: it could not determine the unmet demand because the list was undynamic and highly variable. Why is the department, or the government, reluctant to undertake some form of analysis that is going to ascertain what that unmet need and demand will be?

Dr Studdert: I'd better just check what we said. I don't think there's any reluctance to not understand it. I think that's something we work on.

Senator POLLEY: What is the department doing with the expected home-care package wait list? Do you expect that each quarter it's going to continue to grow?

Dr Studdert: We have tried to answer that. We're tracking that very closely. There's a range of interventions, including a large number of new packages going into the system, and that is what we will track and provide advice to government on as the impact of that infusion is realised.

Senator POLLEY: It's going to be very hard to actually put together the appropriate resources if we're not actually tracking the increase in the demand.

Dr Studdert: That's what our quarterly reporting does.

Senator McKenzie: Yes, it does.

Senator POLLEY: At the time this is released, it will be close to 10 weeks from that data, so how can we plan?

Dr Studdert: As I'd like to think I have explained, there's nothing stopping the system working day on day and week on week. We have to determine at which points in time we capture the data and see what impact it's having. Quarterly seems to be a reasonable point in time. Policy decisions are made on a six-monthly and 12-monthly basis in terms of budget allocations, but I don't think anything dramatic is going to happen from one quarter to the next that would mean we've got our settings wrong and are not delivering to where there's need and resources to be allocated.

Senator POLLEY: Can I ask how many people with disabilities are getting the home care package?

Ms Buffinton: As far as disability goes, I don't believe we have that number.

Senator POLLEY: Would you be able to take that on notice for us, please.

Ms Buffinton: It's more what constitutes the frailty. We don't have an index of what actually constitutes it—whether it's macular degeneration, dementia, loss of use of muscles in legs and so forth. There's nothing that constitutes what we might term a disability. It's a frailty that—

Senator POLLEY: So how do you define and interpret, then, somebody who needs a level 4 package and has been diagnosed with dementia?

Ms Buffinton: First of all, we have the ACAT assessment. We have guidelines and guidance to ACATs using their allied health professional judgement against a set of criteria of what constitutes level 1, 2, 3 and 4. I think we've provided those guidelines in the past, and we're happy to provide those guidelines again, on what constitutes, therefore, the level of frailty that would be judged for level 1, 2, 3 and 4.

Senator POLLEY: In terms of Torres Strait Islanders and Aboriginal people, can you give me a figure as to how many of those groups are receiving home care packages? Do you have a figure around the CALD background as well?

Ms Buffinton: Yes, we do. For the quarter ending 31 December, 2.2 per cent of home care packages were released to consumers identifying as Aboriginal or Torres Strait Islander, up from 1.9 per cent in the September quarter—noting that that is a voluntary disclosure.

Ms Beauchamp: On top of that, too, we've only focused on two elements of the budget package, residential and home care packages, but there's quite a comprehensive package of initiatives to support people requiring aged-care support. As part of that, the government announced $105.7 million to expand the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. That's supporting an additional 900 Aboriginal and Torres Strait Islander people in remote Indigenous communities. That's on top of the figures Ms Buffinton already mentioned for home care.

Ms Buffinton: On the second part of your question, for CALD—culturally and linguistically diverse backgrounds—a further 23.4 per cent were released to consumers considered of CALD background, up from 22.8 per cent in the September quarter.

Senator POLLEY: With the home care package waiting list that we have, can you provide to us the breakdown, electorate by electorate, of how many people? Because you gather the information from a postcode, have you got those figures that can break down electorate information?

Ms Buffinton: Obviously, we've discussed this through our question on notice series as well. We collect information on aged-care planning regions and that's what we provide in our quarterly report.

Ms Beauchamp: That's available publicly?

Senator McKenzie: They don't collect by electorate.

Senator POLLEY: Wouldn't that be possible to do, because you do have the postcodes? Is it that there are not enough resources to be able to do that? What's the reason why you don't provide it?

Dr Studdert: I think we'd have to take that on notice and look at the resource implications. There's any number of ways you could slice and dice the data. I think we've got a standard set, which is being used now and we'd like to stick to it for tracking purposes. Any other range of analysis—

Senator POLLEY: It would be really useful—

Dr Studdert: We'd have to look at the resource implications of that.

Ms Beauchamp: We'll see if we can based on the data we've got.

Senator POLLEY: Thank you. If we look at the dementia and cognition supplement, the department stated that, 'A diagnosis of dementia alone is not sufficient for payment of the supplement'. What other criteria do older Australians ageing in their own homes have to comply with to receive the dementia and cognition supplement?

Mr Murray: For the dementia and cognition supplement in home care, there is an assessment done under a Psychogeriatric Assessment Scale, or PAS, and the finding of that determines your eligibility. There's quite some detail around what that scale requires. I can provide you further details, if you want that, on notice.

Senator POLLEY: I am interested to know why this is the case and why isn't the department paying the supplement if there's been a clinical diagnosis of dementia? There have been some cases where that seems, to me, to be not in the best interests of—

Mr Murray: The supplement is designed to deal with those moderate to severe levels of cognitive impairment, so it's more than just a pure dementia diagnosis.

Senator POLLEY: On notice, can you give us the reasons and the criteria, because it would be helpful to understand that better?

Mr Murray: Sure.

Senator POLLEY: How much of the dementia and cognition supplement, the $40 million for 2017-18, has been spent?

Mr Murray: I'd have to take that on notice.

Senator POLLEY: You don't have those figures?

Mr Murray: Not those detailed figures, no.

Senator POLLEY: Does the supplement increase over the forward estimates? Can you provide a breakdown of the supplement in the past four years and across the forward estimates?

Mr Murray: I'll have to take that on notice as well.

Senator POLLEY: How many older Australians does the $40 million support each year?

Mr Murray: I'd have to take that on notice as well.

Senator POLLEY: Is it correct that a level 4 package attracts a daily dementia and cognition supplement of $13.59?

Mr Murray: The dementia and care supplement is 10 per cent of the level of package you're on.

Senator POLLEY: Is it correct that under the ACFI behaviour domain, that the highest level of funding for a resident is $36.19 per day?

Mr Murray: That sounds about right, yes.

Senator POLLEY: Why is there a disparity when it comes to supporting those with a diagnosis of dementia in a residential aged-care facility and those who are able to stay at home?

Mr Murray: They're quite different funding mechanisms that apply between residential care and home care. Residential care uses a detailed analysis under the Aged Care Funding Instrument looking at your behaviour, your activities of daily living and your complex healthcare needs. It's quite a different mechanism to what applies in home care. Home care funding is provided at the different levels of package—level 1, level 2, level 3 and level 4—with additional supplement available for those with those conditions I mentioned earlier. It's quite a different funding mechanism. They're not really comparable.

Senator POLLEY: But somebody who has the capacity to be able to stay at home—with the support of their family and getting support with a home care package—having had that diagnosis, shouldn't it be the same as when somebody is residing in a residential home? Why should someone in residential care get more money and assistance than somebody who's been able to stay at home?

Dr Studdert: I think it goes to the cost of service delivery and the extent of that in terms of the—

Senator POLLEY: It's much cheaper to have somebody living at home.

CHAIR: We will have to break there as it's 9.15 pm.

Proceedings suspended from 21:15 to 21:29

CHAIR: We will resume with outcome 6: Ageing and Aged Care. Senator Siewert, you have the call.

Senator SIEWERT: I wanted to ask about a couple of the budget measures before going onto a few other issues and go as far as I can go before the chair pings me. Can I go to the budget measure about the child navigator which we touched on briefly earlier—$7.3 million

was provided over two years; that's correct, isn't it? First off, how did you assess the $7.4 million? What assumptions and assessments was that based on?

Mr Smith: Through the budget considerations, there were a number of processes that went into the various aspects of the ageing package, including how to respond to aspects of the Tune review. In terms of how this one was costed, it was part of the budget process. The decision was taken that it would be a pilot. We did some internal work about supporting a costing process around the various aspects that would contribute to that trial, and it's the costing that resulted from that and as was agreed with the Department of Finance.

Dr Studdert: Just to just add to that, we have been specific about what we are aiming to deliver in trial in terms of the numbers of information hubs, community hubs and full-time specialists in consumer-focused organisations. Those are all variables that can be costed and factored into the trial from which we'll get data and feedback on whether they're successfully addressing those barriers that were identified.

Senator SIEWERT: If you don't have it handy, can you take on notice how much one of the information hubs costs and how much one of the community hubs costs—what are the budgeted costs for the provision of those hubs?

Ms Mond: It's certainly the case that they can be delivered in a number of ways. The idea of running pilots is to do it in quite a comprehensive way and actually trial some possible different approaches to establishing both information hubs and community hubs. That will be part of the trial to see the various ways in which they could be done.

Senator SIEWERT: For the 30, there's not particularly one model—is that what I understand from that?

Ms Mond: That's correct; there's been some costing assumptions to come to the figures—

Senator SIEWERT: For different models?

Ms Mond: No, not for different models, but assumptions underpinning the costing of that whole proposal. It would be in the vicinity of around 30 aged-care information hubs and 20 community hubs that we would trial through the pilot.

Senator SIEWERT: What I thought I heard you say was that there may not be one specific model for the information hubs.

Ms Mond: That's correct.

Senator SIEWERT: So, how many different types did you model?

Dr Studdert: I think we'd have to take that on notice, Senator. Again, my colleague might be able to assist but there may be some market processes that we go to to get competitive process around who delivers these trials, so we just have to be cautious about the probity issue.

Senator SIEWERT: We're not going to start that again, are we: you can't tell how much something's going to cost because it might go to tender?

Dr Studdert: We've got indicative costs and we've obviously got a global budget—is that correct?

Ms Mond: Yes.

Dr Studdert: I don't want to compromise that process in terms of putting the proper market forces into play here in terms of getting innovative approaches to this measure.

Senator SIEWERT: The first two measures—the two hubs—are going out to commercial tender. Is that the point?

Mr Smith: We're still in the design phase of the pilot. We have commenced a consultation process with the sector, as well. We'll be wanting to speak to them about the way in which this pilot could be delivered in a way that will deliver the best results to inform future decisions. We're not saying it certainly will go to open market. It's certainly a be possibility, and to the extent that it does we need to be careful about putting dollar figures at that level of detail on the record.

Senator SIEWERT: Just to be clear, this whole process is a pilot?

Dr Studdert: . Yes, the whole process is a pilot. But within it there are four programs that will be trialled, and within each of those there may be different approaches. So we really are going to have a lot of information that will help us with addressing this.

Senator SIEWERT: Is it planned that the community hubs and the information hubs will roll out at the same time?

Dr Studdert: They will roll out over the two years 2018-19 and 2019-20. We are still determining the exact time frames as part of the design process.

Senator SIEWERT: I have heard what I have been told about not wanting to tip off people around the tender process, but how much have you budgeted for admin. costs? This really, and I can see the minister looking at me intensely—

Senator McKenzie: We just want to get value for money, and if we say how much is on—

Senator SIEWERT: I understand that, but it also makes estimates—and it's happening not just here but in other places that we keep being told: 'That's for publication, because we're going to tender,'—very difficult when we're trying to work out value for money and do our job. I'm trying to work out, out of these hubs, how much is going to be eaten up by overheads, administration et cetera? What have you budgeted for in terms of percentage? Let's put it that way, as a percentage.

Dr Studdert: The overheads in terms of the department's administration—

Senator SIEWERT: In terms of the community hubs in particular.

Dr Studdert: or the people that are delivering it in the community setting?

Senator SIEWERT: Yes, for all four of the components.

Mr Smith: We'll have to take that on notice.

Senator SIEWERT: All right. I'm aware of time, so I'm not argue with you about it. I'll save that for another time. If you could take that on notice it would be appreciated. Is it also anticipated that you're looking at these not just as being versus each other in terms of the approach but as taking an integrated approach across the community hubs, the information hubs and the support people?

Ms Mond: Absolutely. As you have just described that, certainly our early engagement with the sector has stressed the importance of looking at the integration between the things that we're attempting to test as part of this trial.

Senator SIEWERT: I've got the information sheet about this. It doesn't articulate very well, or much—or not at all, in actual fact—what some of the principles on which you're basing these are and what will be measured as outcomes. Do you have that material available? What do we see as success out of this measure?

Ms Mond: We'll be doing that work as part of the design and the engagement with the sector that's currently underway. As you know, this measure responds to recommendation 23 of the Tune review. Part of the early work is really describing the system navigator as a concept and doing some work with the sector about exactly what that needs to cover and then how we would measure those outcomes.

Senator SIEWERT: Will that be publicly available once you've done that?

Dr Studdert: I expect the design parameters will be because we'll have to go and consult with the sector, and then go to market in some instances. I would assume and expect that we'd be doing an evaluation both of the individual components and then at the end of the two years how well we've actually responded to the need and barriers that the Tune review identified.

Senator SIEWERT: What are the locations of these hubs?

Mr Smith: It's to be determined.

Senator SIEWERT: What's the time frame for making those sorts of decisions?

Dr Studdert: Work starts now, Senator. It's started already. We have already been in consultation with a range of stakeholders around all of these measures. Our commitment to the sector is to engage in a lot of detail now and going forward for how we implement it and how we map this out so that we do have some good data and results at the end to advise government how to go forward.

Senator POLLEY: Can I ask if you have any preferred sites?

Dr Studdert: No, Senator, no preferred sites.

Senator SIEWERT: If you take the questions I have asked on notice, we'll obviously be following this up in other estimates. I'm aware of time, so I'll move on to one of the other initiatives, which is the impact analysis of allocating residential care places to people seeking care rather than to the providers of that care. Can I ask again, how did you determine that level of funding—the $0.3 million?

Dr Studdert: Again, we would have done some costings with a range of assumptions about what it would cost to do this analysis, including the consultation that's necessary. This is actually something that the department has quite a lot of experience on, in terms of processes where we do data analysis and consultation processes with the sector. So I think that's where we could probably pretty readily come up with that figure.

Senator SIEWERT: In terms of what's to be included in the impact analysis, have you determined that yet? What are the parameters that will be included?

Ms Grinbergs: We are in the process of consulting with the sector on the scope of that impact analysis, because we want to ensure that it does pick up all of the potential risks and

ramifications of a change, and also so that it's able to inform an alternative allocation process or an alternative approach to the current aged care approvals around.

Dr Studdert: Should that be a decision made based on the analysis.

Senator SIEWERT: I understand that.

Dr Studdert: Of course, we're building on advice and information that was captured on the Tune review. So that's a pretty solid starting point.

Senator SIEWERT: In terms of how you're going to do about doing it, are you planning on a consultant taking on that work?

Ms Grinbergs: It will be external.

Senator SIEWERT: An external consultant from a shortlist?

Ms Grinbergs: That's still to be determined.

Senator SIEWERT: And the time frame for delivering the actual report?

Ms Jolly: That's still to be determined. We haven't started the procurement process yet, so we couldn't give you a time line. The money is available in the next financial year.

Senator SIEWERT: Within the next 12 months—is that the idea?

Ms Jolly: Yes.

Senator SIEWERT: Well, before that to inform the decision-making, then for the future.

Dr Studdert: To complete the analysis and to provide advice to government.

Senator SIEWERT: We've heard lots of comments around the ACAR round. So is the plan to make the next one start moving towards that?

Dr Studdert: No, that is absolutely not the case. We continue with the current funding formula.

Senator SIEWERT: In that case, is there a planned date if the decision—

Dr Studdert: I would have to say no.

Senator SIEWERT: Sorry, I realise this is still a decision to be made. But there must be a time line for when the decision has to be made or when you anticipate it.

Dr Studdert: I don't think so, actually. I think this is a fairly major decision and one I would expect government would be want to consider very carefully and to work very closely with the sector on for any changes that would be made, whatever they may be—whether they are along the lines of this or any other changes. So I expect there is a long lead time to that process.

Senator SIEWERT: So no actual time has been set by which a decision has to be made?

Dr Studdert: No.

Senator POLLEY: Could I go back to when we were talking about the difference with the money available for people who have been diagnosed with dementia at home verses those in residential care? My understanding is that only 12 per cent of those who are diagnosed received a supplement in home care, while more than 50 per cent of residents are receiving ACFI funding for the same terminal condition.

Mr Murray: I don't have those details available. I'll have to take that on notice. In general, I would reiterate the point that it's quite a different arrangement comparing home care

to residential care, because the needs that people have in residential care are quite significant and different, which is why we use a whole different funding tool to allocate funding which takes into account their behaviour needs, complex healthcare needs, mobility and so on. It is not the same assessment process that we use in home care, but I can certainly take on notice your question around the rates of usage and so forth.

Senator POLLEY: That'd be great. My understanding is the budget allocated $5.3 million over four years for the development of technological solutions to support people living with dementia. Am I accurate?

Dr Studdert: That's correct.

Senator POLLEY: Can the department confirm whether this was the only funding allocated for the second leading cause of death in Australia in the 2018-19 budget?

Mr Smith: This is only the dementia-specific budget measure, although if you look at the additional investments across the aged-care sector, as you've noted, with the prevalence of dementia in the community the significant additional investment through the broader aged-care package does support people with dementia in that way. That's in addition to the existing supports for dementia that are already and ongoingly funded.

Dr Studdert: In the health system—the MBS, the PBS and the public hospital funding—there are a whole range of ways that dementia care is funded. It's actually quite hard to get a handle on that, but this is a particular measure that the government wants to look at in terms of an innovative approach to using technology to improve the quality of care.

Senator POLLEY: Can you outline to us what sort of options have been looked at? What will this money fund?

Ms Mond: The $5.3 million has been committed over three years, and it's really around pilot improvements. We'll be looking to really identify what innovative technologies are out there that could be supportive of people with dementia either in the home care environment or the residential care environment. We'll really be looking to uncover, as broadly as we can, what types of technologies are out there and which ones are complementary to the technologies that we already see and that we have in some of our current, ongoing funded projects, like the consumer supports program, where we've already seen quite a few very innovative technologies being used to support people with dementia.

Senator POLLEY: There are no provisions—have I understood this correctly?—to assist care providers delivering quality care to people living with dementia through the Dementia Training Program, the Dementia Behaviour Management Advisory Service or the severe behaviour response teams?

Mr Smith: Sorry, what was the question in relation to those programs?

Senator POLLEY: In other words, are there any provisions to assist the providers who are delivering the services, like the Dementia Training Program? What's the allocation money for there, or is there no—

Dr Studdert: Do you mean in the budget?

Senator POLLEY: Yes.

Dr Studdert: No. There's no additional funding for those, but we can certainly take on notice to give you some advice on the current funding levels.

Mr Smith: We can provide them.

Ms Mond: I can give you some of those figures now. On an annual basis currently, for example in 2016-17, there was $38 million allocated to the provider training and behaviour management support programs—that includes the Dementia Behaviour Management Advisory Service, the severe behaviour response teams and Dementia Training Australia.

Senator POLLEY: What time period was that allocation for?

Ms Mond: That's annually in the order of $38 million.

Senator POLLEY: For the forward estimates?

Ms Mond: Yes, it's a similar amount. It varies very slightly, but, yes, it's annually.

Senator POLLEY: What work has been done so far to progress the Specialist Dementia Care Units? When will places be released?

Ms Mond: We have currently just completed some consultation with the state and territory jurisdictions around the design of the model of care that we will be rolling out. I'll just check specifically for dates. We're hoping to finalise design and ready to go back to government middle of this year, in the coming months, with a final policy design on the specialist dementia care units, and then be running advertising for funding for the first units by the end of this calendar year.

Senator POLLEY: Can you give us an update on the work of the severe behaviour response teams? What work has been involved? Is it working? Is it successful?

Ms Mond: We are finalising an evaluation of the severe behaviour response teams. It is considered the second tier of servicing currently and the specialist dementia care units would introduce a third tier of servicing. We also are considering the role and the pathways they would play in terms of referring where a higher need of care is required, so they're certainly part of our work on the specialist dementia care units, also.

Senator POLLEY: Okay. I would like to move on to the aged-care workforce. The Minister for Aged Care has said that, by 30 June, Australia's first aged-care workforce strategy is due to be completed. Will this be adopted as government policy?

Ms Jolly: There is a workforce task force that is being led by Professor John Pollaers. That task force is developing an industry strategy and that industry strategy is on track to be delivered to government by the end of June.

Senator POLLEY: So is it anticipated that the government will adopt the recommendations?

Ms Jolly: I can't speak on behalf of a government response but I can tell you that the strategy really is an industry-facing strategy. I have heard Professor Pollaers talk across the industry about the domains of the strategy, and a lot of it is really about how industry might change the way it does things in order to reposition itself to be an employer of choice and what sort of structures and processes it might put in place to deliver on that end goal. So, whilst we certainly haven't seen the final design, that is the general shape of the strategy, as I have heard it being presented from Professor Pollaers.

Senator POLLEY: So that's due to be brought down by 30 June. Is that when it will go to the minister?

Ms Jolly: That would be my expectation.

Senator POLLEY: And we could expect government response, Senator McKenzie, when?

Senator McKenzie: In due course.

Senator POLLEY: Okay, I had to try.

Senator McKenzie: No, that's fine. Just while I've got you Senator Polley, you did tweet yesterday, 'Breaking: No, not one new dollar for aged care'. Now that you've actually had the chance to prosecute that question—

Senator POLLEY: 'Not one extra dollar'.

Senator McKENZIE: with the department—and I think they've taken you through quite a detailed analysis of the budget measures and the additional funding the government has put towards aged care, are you prepared to retract that tweet?

Senator POLLEY: No, because it's a fact. Actually the process here in estimates is I ask you questions; you don't ask me.

Senator McKenzie: It's actually not a fact.

Senator POLLEY: It is a fact. There's no new money. That's what the department said yesterday. Has the aged-care industry reference committee structured—

Ms Beauchamp: Can I just clarify that comment there. There has actually been a net increase in funding allocated to aged care.

Senator POLLEY: Can we move on to—

Senator McKenzie: So will you be retracting the tweet?

Senator POLLEY: No, I won't be retracting the tweet.

CHAIR: Retreating your tweeting?

Senator POLLEY: Can I move on, Chair, to—

CHAIR: You have the call, Senator Polley.

Senator POLLEY: to the issue around the aged-care industry reference committee structure and the membership. Has that been finalised? If not, when will it be? What steps are next for that committee?

Ms Grinbergs: That's a matter for the department of education. That committee will sit under the Australian Industry Skills Committee. As I understand it, they have gone out for consultation in terms of what the scope of that membership should be. They are considering the outcomes from that consultation. They will then move to the next step, which is seeking nominations for people to sit on that committee.

[21:55]

Senator POLLEY: I'm ready to go on to the agencies, if we can—the Aged Care Quality Agency. Mr Ryan, can you give us an update, please, of those providers that have not been able to meet the criteria in South Australia? Following on from the Oakden report and hearings we had then, you identified there were a number of others in South Australia that also didn't meet the standard. And recently, unfortunately, there was news about lack of care in a Queensland residential home.

Mr Ryan: We've undertaken compliance monitoring and have made decisions with regard to a range of homes. Can you be more specific in terms of the South Australian homes? I might ask my colleagues—

Senator POLLEY: You reported at the hearings that there were a number of other aged-care places in South Australia that didn't meet the criteria.

Mr Ryan: That's correct.

Senator POLLEY: Can you advise us as to whether that's still the case or whether they have been brought up to standard?

Mr Ryan: In some cases—and I just need to check whether appeal periods have been concluded—we have revoked accreditation in South Australian Homes, and we continue to undertake compliance monitoring of some homes in South Australia where we have found outcomes not met. I'm just going to bring up the system. I might ask Ann Wunsch, Executive Director, Operations, to address that specific question with regard to South Australian homes.

Ms Wunsch: We have information about two specific homes in South Australia, but I would need to understand the homes that you are referring to.

Senator POLLEY: What about Queensland?

Ms Wunsch: There are 500-plus residential aged-care services in Queensland, so are there specific services that you are seeking information about?

Senator POLLEY: There was a home sanctioned in the last couple of weeks in Queensland that made it to the media. I don't have the clips with me, but if you can't speak to that, can you give me a state-by-state breakdown of those residential homes that haven't met the standards?

Ms Wunsch: I could provide you with numbers of services that don't meet standards across Australia for a given period, if that's what you're seeking.

Senator POLLEY: Yes, for the last 12 months.

Mr Ryan: I think that the information we have with us tonight is for the financial year to date, or up until the end of last month.

Senator POLLEY: Okay.

Mr Ryan: If you're happy with that, we'll be happy to speak to that now. If you seek 12 months data—

Senator POLLEY: That's fine. That'd be good—very useful.

Mr Ryan: You are specifically asking about noncompliance in homes?

Senator POLLEY: Yes.

Mr Ryan: Our data with regard to homes dealing with noncompliance, if we look at the background—this is new, not expected outcomes, residential aged care, so that's different to home care—in the year to date until the end of April 2018, that's the financial year to date, we have undertaken 811 reaccreditation site audits. The number of times that we have judged that homes have not met outcomes is 39. In addition, we've undertaken a review audit—you would be familiar with that—where we go into a facility where we're concerned around performance; we might find one or more outcomes not met, and we decide to do a full and comprehensive review of them, outside of their normal three-year cycle. In the financial year

to date, we've undertaken 52 review audits, and we've also undertaken 413 announced assessment contacts. These would be additional contacts where we might have found an outcome not met. A finding of 'not met' against an outcome triggers a number of other processes, and, depending on the nature of the failure that we've found and on the overall health of the home otherwise or of the provider group, they then determine what type of action we take.

Senator POLLEY: How many referrals have you had from the Department of Health to conduct a follow-up visit service?

Mr Ryan: I do have that data here. Just give me one moment—

Ms Mond: I have that data here.

Mr Ryan: Okay; I'm happy for Ms Mond to answer that in terms of referrals from the department.

Ms Mond: In the year to date, as at 30 April 2018, the department had made 760 referrals to the quality agency.

Senator POLLEY: Can you break those down state by state?

Ms Mond: I don't have that with me.

Senator POLLEY: If you could take it on notice, that would be great. Has the government undertaken any consultation with regard to the agency in relation to the merging of the Aged Care Complaints Commissioner and the Aged Care Quality Agency?

Dr Studdert: You'll be aware that that was announced by government as the intention now, in response to the Carnell-Paterson review. The department will be leading that process and, yes, of course we'll be consulting with the management and staff of each of the agencies, as they will be directly affected, and the process is now just starting.

Senator POLLEY: When do you anticipate that consultation process will have been finalised?

Dr Studdert: It will be done in the coming months, because we are being asked to and are expected to deliver the new structure, with the two agencies combined, by 1 January.

Senator POLLEY: What consultation has occurred with the agency in the lead-up to the tabling of legislation around quality standards, and who did the agency consult with?

Ms Laffan: That work was undertaken by the department. There has been significant consultation on the quality standards. We have a technical advisory group made up of experts. We have gone to public consultation where we put a survey up and did some roadshows in regional areas. We've done a couple of webinars. We've had multiple versions of the draft standards, as they progressed, on our website. In addition to that, the quality agency has been undertaking a consultation process on the guidance material that underpins the standards.

Senator POLLEY: I wanted to ask this question earlier but I'll ask the department now. The minister announced that the sector should mandatorily offer flu injections to their staff. Can you tell me what uptake there has been and whether or not you're recording any information about a provider and how many of their staff have actually taken the option of having the flu injection? We've heard in the news that there's rationalisation going on around the flu. We also know that too many older people died from the flu last season. So is there any information you can update us with?

Ms Laffan: Just to clarify: that measure came into effect on 1 May this year. One of the components of that measure is that providers keep records of the number of staff that receive a flu vaccination each year. I must say that that doesn't specify whether that's been through their program or not. So I, as a private citizen, could go out and get a flu shot; that would still be recorded, even though it wasn't offered as part of the program.

Senator POLLEY: That's good.

Ms Beauchamp: I think, based on the earlier discussion, we said we'd take that on notice, in terms of the data that we have.

Senator POLLEY: Fantastic.

Senator SIEWERT: Can I go back to the standards. You outlined the consultation process. Where is the process up to now?

Ms Laffan: We're at the stage where, very recently, the quality agency undertook a piloting process. We got the results of those pilots and went back to our technical advisory group and, as a result, have made some, I would say, final refinements to the standards.

Senator SIEWERT: Can you share with us what came out of the pilot of them?

Ms Laffan: I'd have to hand that over to the quality agency, as they conducted those pilots.

Senator SIEWERT: In terms of piloting the new standards, what were the learnings from that process?

Mr Ryan: There were significant learnings around the trialling of the new standards. In fact, Christina Bulger, executive director, regulatory performance and policy, led that work. Christina, if you could answer the senator's question.

Mrs Bolger: Sure. Primarily we were interested in testing the standards for their measurability and how we could assess those in a range of settings. Our pilots had three phases. One was just an early online testing, which gave us an opportunity to ask some very targeted questions of the sector around the standards. We were looking for things like points of difference so we would understand the work that was needed to support the sector in areas where the change was greatest. We also—

Senator SIEWERT: When you talk about the sector, are you talking across the board so consumers could participate in the online process as well?

Mrs Bolger: The online process was targeting providers specifically because it was the first phase, but, in testing, it was actually tested in a live audit environment so we were able to test with consumers in audit conditions in the field. We undertook that at 22 different services to satisfy ourselves that they were measurable and that consumers could respond to lines of questioning around the standards and the expectations that they were setting. We have done some further work with consumers, which I can speak to if you would like. But, on the pilot specifically, to go back to your question about what the learnings were, we were able to identify where there were some standards that overlapped in their intent, and so that information was helpful in refining the standards through the technical advisory group. We also identified some gaps where there were concepts that weren't well covered in the standards. They weren't significant changes but, in testing, they were helpful to further refine the standards.

Senator SIEWERT: Those were the two key learnings? Is it possible for you to provide a summary—I'm pre-empting this by saying 'in the relatively near future', not when answers are due, given the time frame on these?

Mr Ryan: We'd be happy to. We've done very extensive work in this area and we'd be very happy to share it in summary form.

Senator SIEWERT: I think this is going to be a longer conversation. There are a lot of points there. If you could provide that, that would be extremely useful. You said there were three points. There was the online process. I apologise, because I interrupted you, but I wanted to know who was participating in that. So that was providers?

Mrs Bolger: Yes.

Senator SIEWERT: Then there was the trialling in 22 services?

Mrs Bolger: Yes. The first part of that was field testing with 11 service providers, which was the first part of our field testing. We looked at individual standards and the guidance and tested that in a range of settings. Then the third phase, which was completed just at the beginning of May, was the full audit, an end-to-end audit. So we ran the standards together and we sought to understand the full audit and any unintended consequences or any changes or overlaps in the standards as a whole.

Senator SIEWERT: All of that then formed the learnings?

Mrs Bolger: Yes.

Senator SIEWERT: And that's what you'll make available?

Mrs Bolger: Correct.

Senator SIEWERT: Thank you. When you're talking about the guidance, my understanding is that's separate to the standards, isn't it?

Mr Ryan: Correct.

Senator SIEWERT: The standards are a legislative instrument, but the guidance isn't. Is that a correct understanding?

Mrs Bolger: That is correct. The guidance is guidance.

Senator SIEWERT: In terms of enforcement and when these are being assessed against, how will the assessors take into account whether people have met the guidance, and are there then any actions or determinations that may be made against the standards? I'm thinking in a negative capacity: for example, they haven't met the standard and they rely on the guidance, which is not a legislative instrument.

Mrs Bolger: Our intention isn't that the sector rely on the guidance. The requirements are set out clearly under each of the standards. The guidance is to assist providers to understand the intent of the standards, ways in which they could demonstrate evidence, and examples such as case studies and links to other sources of information. So it is really a suite of resources that helps the sector to understand the intention of the standards.

Mr Ryan: That's why we're spending 12 months, starting on the first of the next financial year. You'll be aware that the full implementation of the new standards won't take effect until 1 July next year, and so we have significant work of engagement with the sector, which includes consumers, to provide significant education and information to help providers

understand what the new standards require. There are significant new areas, especially around consumer involvement and consumer voice within the new standards. Given that the soon-to-be expired standards go back almost 20 years, consumer voice was not a concept that had a lot of currency.

Senator SIEWERT: Exactly.

Mr Ryan: Standards were a dialogue between the government and providers. Of course, in this day and age, we would never imagine speaking about aged care without consumers being front and centre. So the new standards give effect to government's commitment and to community expectation around consumers front and centre. We have a 12-month transition period, significant resources and significant education. Our Better Practice conferences, which we run annually, will be Better Practice events. They will be practitioners' workshops, not just conferences. This is to help practitioners understand and deliver government's intent for a new set of standards that reflect older Australians' expectations around care.

CHAIR: Can I jump in with a follow-up question? We had a discussion at the last estimates about balancing the need to step in to get a facility up to standard with when you step in to shut down a facility which is so grievously in breach of its obligations to its residents.

Mr Ryan: Yes.

CHAIR: Do the standards inform that decision-making process?

Mr Ryan: For failure against the standards, it would depend on the breach—against which outcomes and which standards. Certainly, if we find that there's failure against the standards, or multiple failures against the standards, and a serious risk that one or more identified residents have been placed at serious risk to their health, safety and wellbeing, and where we find that it's not viable even with a timetable for improvement and with whatever assistance is provided, the safety and wellbeing of the residents is paramount. That's always case by case. In making a revocation decision, we must take in hand the findings of the audit report, any response from the audit findings given by the approved provider, and relevant information given to the quality agency or the assessment team by care recipients or their representatives. So it's not just what we think; it's the lived experience of the residents and their family, relevant information provided by the Department of Health or by the complaints commissioner, and whether we're satisfied the approved providers are able to or will undertake continuous improvement. They're the statutory steps at the final stage. Revocation of accreditation is rare, but we've undertaken it a number of times in the last 18 months, and we think that's a sign of a system that keeps residents front and centre.

CHAIR: Do the new standards clarify that?

Mr Ryan: I think it's important to note—and Ms Laffan from the department would be able to speak more clearly—that failures against the standards and the regulatory framework will remain intact even though the standards which we're measuring against will, of course, be changing. I will pass to my colleague.

Ms Laffan: Just to confirm that it's what the services are measured against, not the actions that are taken if they fail to meet those standards.

CHAIR: Okay, fair enough.

Senator SIEWERT: Can you say that again? It's the—

Ms Laffan: In a sense, we're changing the rules, not the consequences.

Senator SIEWERT: Yes, okay. Can I go back to the issue around 19 about transitioning them in. We'll see the legislative instrument—when?

Ms Laffan: I'll answer that if I may. You would have seen that the bill was introduced into parliament last week—

Senator SIEWERT: Yes.

Ms Laffan: and that lays the foundation. The standards themselves are made under the Quality of Care Principles, and they are something that the Minister for Aged Care signs off on. And our hope, our expectation, subject to the passage of that bill—

Senator SIEWERT: The enabling bill?

Ms Laffan: is that the new principles will be in place so that the standards can take legal effect from 1 July this year.

Senator SIEWERT: So we'll see the standards some time between now and 1 July?

Ms Laffan: That's correct.

Senator SIEWERT: Just coming back here, are we able to get that report before the standards are tabled or as the standards are tabled so that we can actually see how they're reflected in the new standards?

Mr Ryan: We will do that as quickly as we possibly can.

Senator SIEWERT: Thank you. Can I go back to the details you were just referring to for Senator Polley about the audit reviews and the announced assessment contacts. Did I get it right on the 39 issues ? Can you take me through that again? I thought you said you had 811 accreditation visits.

Mr Ryan: I'll just go to our performance report, which we'll be happy to table. There is a great deal of data, so it would help me if you could refine the question. I'm happy to answer it.

Senator SIEWERT: I just want you to repeat the numbers you gave to Senator Polley, because I missed the first two.

Mr Ryan: I see. For reaccreditation site audits—they're the regular ones, done for most services every three years—we've undertaken, in the financial year to date to the end of April, 811.

Senator SIEWERT: Yes.

Mr Ryan: Thirty-nine times we've found that provider has not met all 44 expected outcomes.

Senator SIEWERT: That's what I wanted to double-check. Thank you.

Mr Ryan: That's about five per cent, rounding up. The number of review audits has been 52. Out of that, where we've found concerns—concerns might come to us because of what we observe on site, and concerns will come to us even more frequently from the complaints commissioner, who has referred hundreds of issues to us—we take them on board and, depending on her assessment, we will then look at those matters either next time we're in or all the way through to getting in there immediately. We've conducted 52 audits. They're

review audits. They're not the normal audits done every three years. The number of times we've found expected outcomes not met is 42 out of 52. That's 81 per cent. So, when we have good regulatory intelligence, we go and assess a home, and those referrals from the complaints commissioner and from the department and other regulatory intelligence are borne out with what we find.

Senator SIEWERT: Of those 42, where are they at now?

Mr Ryan: The vast majority of those would be on or may have already served, because it's the first nine months of the financial year.

Senator SIEWERT: They are already served?

Mr Ryan: Some would them would have already completed a timetable for improvement and would have been able to demonstrate that they returned to full compliance.

Senator SIEWERT: How many of those have done that?

Mr Ryan: During this period, of the number of services that did not resolve to meet all expected outcomes, eight out of the 42 continue to have noncompliance.

Senator SIEWERT: What's the process? Where are they at in the cycle now?

Mr Ryan: We take that on a risk basis, depending on the nature of the noncompliance. We might place them on an additional timetable for improvement. If we found serious risk, we would refer that to the secretary or her delegate and that delegate might apply sanctions. We might reduce their period of accreditation to two years, one year, six months. That would depend based on the case.

Senator SIEWERT: So 34 have now returned to compliance? Is that how I understand these figures?

Mrs Bolger: Some of them may still be in a timetable for improvement, because our reporting period is just a reporting period.

Senator SIEWERT: Can you take on how many of those there are?

Mr Ryan: Yes.

Senator SIEWERT: Do you have that data available?

Mrs Bolger: We can table that and we'll take your question on notice.

Senator SIEWERT: If you could, that would be appreciated. Of those eight, have any of those now been referred to the secretary?

Mr Ryan: Every time we find noncompliance, we inform the secretary, as is our responsibility under—

Senator SIEWERT: So, of those eight, all have been referred to the secretary?

Mr Ryan: Every finding of noncompliance, irrespective, is always informed to the secretary or her delegate.

Senator SIEWERT: Where are those eight up to?

Mr Smith: We may need to take parts of it on notice. We'll attempt an answer and then see where the gaps are and whether we need to take some on notice.

Ms Mond: We may, in terms of the actual eight, because I'm not sure of the reporting period and don't want to make a mistake on the exact date that we're referring to. But I do

want to say that the department assesses all information that we receive from the Australian Aged Care Quality Agency to determine the most appropriate and proportionate response based on the identified risk to care recipients. So this action is aimed at protecting current and future care recipients' health, welfare and interest and returning the provider to compliance. As Mr Ryan said, for every case audit we receive advice from the Quality Agency where they think there is serious risk and we will look at that and determine whether we think we need to either impose sanctions or a notice of noncompliance.

Senator SIEWERT: Have any notices of the noncompliance been served or any sanctions imposed on those eight?

Ms Mond: Currently we have quite a number of notices of noncompliance and sanctions that are open. I will take it on notice in relation to the specific eight.

Senator SIEWERT: In that case, how many notices of noncompliance do you have open and how many sanctions applied?

Ms Mond: We currently have five active sanctions and we have 64 active notices of noncompliance across quality and prudential standards.

CHAIR: We will need to go back to Senator Polley—so last question.

Senator SIEWERT: How long do people get when they've had notices of noncompliance—those 64?

Ms Mond: It depends on the circumstances and their degree of 'unmets'. It would vary depending on the case.

Senator POLLEY: Earlier in the questioning I asked whether or not you could table the document that the officers referred to when we were discussing the Tune report. Just to clarify, I didn't want the Tune report—we're well aware of that. It was the document that the staff were referring to and speaking from. You said that would be tabled, and we haven't seen it.

Dr Studdert: I have it here. I was just waiting for the right opportunity. I can table this document.

Senator POLLEY: Excellent; thank you. My next lot of questions will go to the Aged Care Complaints Commissioner. Can you bring us up to date on the undertaking by the commission to ascertain whether or not unspent funds have been appropriately returned by providers to the estate of the care recipient?

Ms Lamb: Sorry, Senator Polley, I'm not sure what undertaking you're referring to. From the way it's framed, it doesn't sound like it's something that is actually within my purview.

Senator POLLEY: Oh, okay. Do you have any responsibility to oversight the return of estate moneys by aged-care providers?

Ms Lamb: No.

Senator POLLEY: Have you had any referrals from the department to investigate complaints in residential aged-care facilities?

Ms Lamb: I don't have that figure in front of me at the moment. The department is, of course—as is the Aged Care Quality Agency—able to make referrals to me. I can act on any information I receive from any source, whether it's a complaint or information raising

concerns about a service provider meeting its responsibilities. I can take that on notice if you would like.

Senator POLLEY: That would be good.

Ms Mond: Ms Lamb, I've got that figure, I think—

Ms Lamb: Thank you.

Ms Mond: about the referrals from the department to the complaints commissioner. As at 23 May 2018, year to date, there have been three referrals from the department to the commissioner.

Senator POLLEY: Can I ask what those referrals related to?

Ms Mond: All three referrals were in relation to fees and payments.

Senator POLLEY: How many complaints would you receive annually in relation to home care?

Ms Lamb: Home care, as I think I've said previously at estimates, is an area where we've seen significant, ongoing growth in terms of complaints to us. When I took over a couple of years ago, it was about seven per cent of all complaints. Now close to 25 per cent of the complaints we receive are about the various forms of care that are delivered to people's homes and in the community. Last year's figures, of course, are in the annual report. For the year to date, we've received 989 complaints relating to care at home. That's out of a total number of complaints, for the year to date, of just over 4,000.

Senator POLLEY: What's the general nature of the complaints or concerns raised around home care?

Ms Lamb: The top issues are largely around fees and charges—the clarity of statements, the kinds of fees that are being charged—and the lack of consultation and communication. Related to that are complaints around client care and coordination, like whether or not it is communicated to people that someone is going to be late, there has been a change of carer or someone's not going to turn up. Those sorts of issues are the most common ones.

CHAIR: I take it the committee agrees that we accept this as a tabled document?

Senator POLLEY: Yes.

Senator SIEWERT: Yes.

Senator POLLEY: In residential care, what's the nature of most of the complaints?

Ms Lamb: In residential care, the five top issues are clinical in nature, and that's been the case for quite some time. The top couple of issues are medication management and administration. Falls are a big issue, and things like personal care and oral hygiene, constipation, and continence management. The ongoing issue, which we also see in home care, is around communication, consultation with families—those sorts of things.

Senator POLLEY: Have you seen some improvement in these areas? Do the same complaints come to you all the time, or are there some areas where the complaints have reduced?

Ms Lamb: It's 2½ years since I took over responsibility for the complaints scheme from the department. The thing that is of some concern to me is that the top five issues in residential care are very similar to what they were when we started. It doesn't seem to change.

We do have to put that against a background, though, where we are receiving ever-increasing numbers of complaints as well, so it's difficult to read too much into it.

Senator POLLEY: Have you done any analysis about the satisfaction rate of those who make a complaint and the subsequent outcomes?

Ms Lamb: We run surveys and we have, in fact, been working to try and improve our surveying so that we get a higher response rate. We used to send them out, as the old scheme did, with every single decision; now we do it in a more targeted way and we've managed, I'm pleased to report, to increase the number of responses and also the number of complainants and consumers who are responding, because we do survey both parties. Our results show a fairly consistent general satisfaction of around 80 per cent with our process and the way we've handled the complaint. But I'd be the first to admit that there are some people who are unhappy with us because they feel that we haven't been able to deliver on their expectations in terms of an outcome. That's something we take very seriously and we try very hard to understand what it is that they're dissatisfied with and if it is something that we need to do differently or do better.

Senator POLLEY: Where do people go if they haven't been satisfied with the outcome?

Ms Lamb: They can come to us in the first instance if they feel able to. They can appeal against the decision that's been made. And those cases come to me. So I've made sure that I actually am the decision-maker for those cases. It's really good because I can see what my team's doing across the country and the decisions that are being made. If they're unhappy with me or my decision in a subsequent case or if they don't want to come back to us, they can go to the Commonwealth Ombudsman. To date, the Commonwealth Ombudsman hasn't upheld any complaints against us—and I'm touching wood as I say that. We're always open to some feedback if there are things that the Commonwealth Ombudsman identifies and thinks that we need to do, and we do encourage people to go there, but also to talk to us, if they're concerned about us.

Senator POLLEY: Thank you very much. I want to move to the Aged Care Pricing Commissioner. Can you advise the committee as to whether the government consulted you—

CHAIR: Sorry, Senator Polley, I'll just interrupt briefly. I just realised—thank you, Minister—that this is Mr Dicer's first appearance at estimates. Is that correct?

Mr Dicer: In this capacity, yes.

CHAIR: It's great to see you here, and welcome.

Mr Dicer: Thank you very much.

Senator POLLEY: And we don't bite.

Mr Dicer: No, I realise that.

Senator POLLEY: Or not much. Did the government consult with the Aged Care Pricing Commissioner in relation to the 2018-19 budget measure in relation to introducing a levy to secure accommodation bonds?

Mr Dicer: I can only say, in respect of myself, that I've been in the role since 21 May this year—

Senator POLLEY: So you're an old hand at it!

Mr Dicer: Absolutely—and, personally, no.

Senator POLLEY: Is there any documentation in relation to your predecessor?

Mr Dicer: Not that I'm aware of.

Senator POLLEY: Would you be able to take that on notice?

Mr Dicer: I can. I will check for you, and I'll check with the department as well.

Mr Murray: I can assist in that matter. The role of the pricing commissioner is quite specified in legislation around approving accommodation payment prices. The pricing commissioner does not have a direct role in the bond guarantee scheme, which you're referring to. Decisions around that are a matter for government.

Senator POLLEY: Okay, thank you for that. Have you received any inquiries from consumers or stakeholders about the cost of bonds in residential aged-care facilities? Would they come to you if they had concerns?

Mr Dicer: No.

Senator POLLEY: Has the government undertaken any consultation in relation to increasing transparency around the aged-care and home-care fees?

Mr Dicer: I'm not in a position to answer that question.

Senator POLLEY: Would you be able to take that on notice?

Mr Dicer: I can.

Senator POLLEY: Or can Mr Murray help me again?

Mr Murray: Yes. Any issues around policy in the aged-care setting are really matters for government and the department to advise on, rather than the pricing commissioner.

Senator POLLEY: Can you advise?

Mr Murray: Could you repeat the question?

Senator POLLEY: Was there any consultation in relation to increasing transparency around aged-care and home-care fees?

Ms Beauchamp: Are you talking about an initiative of government?

Senator POLLEY: Yes. As I understand, there have been some concerns about, as I said, introducing levies to secure accommodation bonds, and I wondered whether there has been any consultation with stakeholders or consumers in relation to bonds in residential care facilities.

Mr Murray: Certainly, the proposal which has been announced to impose a levy in relation to the Accommodation Bond Guarantee Scheme came about following the recommendation from the David Tune legislated review that a levy be imposed. Of course, there was quite widespread consultation in that process. That report also referenced an earlier report by the Aged Care Financing Authority, which gave recommendations to the government on the Bond Guarantee Scheme and the levy arrangements. ACFA also consulted widely with the sector and put out a public consultation paper on that process.

Senator POLLEY: Thank you very much.

Senator SIEWERT: I want to go back to where we left off with the eight unresolved issues going to the department and then the 64 matters of noncompliance. How do we have

eight from this year but the 64 matters of noncompliance you articulated just before we went back to Senator Polley? I may have misunderstood. I heard that there are five active processes where sanctions have been applied. Is that correct?

Ms Mond: Five active sanctions, yes.

Senator SIEWERT: How long have they been in place? Do they relate to the eight from this year?

Ms Mond: I can walk through those five individually to give you a sense of the time frame. I will list them: the first was on 8 May this year; the second was on 1 May this year; the third was on 17 April this year; the fourth was on 12 January this year; and the fifth was on 21 December last year. That's when the sanctions were imposed.

Senator SIEWERT: And they're still active?

Ms Mond: That's correct.

Senator SIEWERT: If sanctions have been imposed, are these facilities still operating under those sanctions?

Ms Mond: That's correct.

Senator SIEWERT: What are those sanctions for?

Ms Mond: The sanctions do vary. I can talk you through some of the common sanctions that apply. They are things like to restrict the receipt of subsidy for a service to existing residents at the date the sanction is imposed and to revoke a provider's approval unless they agree to appoint an administrator or a nurse adviser and to provide required training to staff. Those are the common types of sanctions that we would apply.

Senator SIEWERT: When do they have to respond by? So, for example, 21 December one, that's nearly six months ago or five months ago.

Ms Mond: Yes. So the expiry on those sanctions is 21 June 2018.

Senator SIEWERT: Are each of them for six months, or do they vary depending on the nature of the sanction?

Ms Mond: That's a very commonly applied period.

Senator SIEWERT: So each of those are now six months. So, at the end of those six months, you do another accreditation?

Ms Mond: That's correct. The Aged Care Quality Agency would do a review against the accreditation standards.

Mr Ryan: That's correct.

Dr Studdert: I don't want to give the impression that we sort of impose the sanctions, walk away and come back six months later. I think there's quite an active process during this time between the department officials and the Aged Care Quality Agency to monitor how that's going and to actively work to get them back into compliance. So there's no lack of visibility as to what the circumstances are in each setting.

Senator SIEWERT: Can I go back to this issue of the 64 notices of non-compliance. Over what time frame had they been issued? Is that this financial year?

Ms Mond: I'll have to take that on notice.

Senator SIEWERT: Did I get that figure wrong, the 64?

Ms Mond: No. That's correct.

Senator SIEWERT: I'm trying to work out, if there are eight matters that have been referred this financial year to you, from the agency, how do we get to 64?

Mr Ryan: Can I hop in here. We haven't referred eight matters; we've referred dozens of matters. Every finding of non-compliance is reported to the secretary or her delegate, and on findings of serious risk—

Senator SIEWERT: Serious risk, okay.

Mr Ryan: So serious risk is a finding that there has been a failure against the standards, and it either has placed or may place one or more identified residents at serious risk to their health, safety or wellbeing—has placed or may place, so it's not specific in timing. We refer to that to the department, and the department have a different threshold test—it's whether there's immediate and severe risk—but I'll refer that back to my colleague.

Senator SIEWERT: I still can't make the numbers add up. You said that out of the 52 audit reviews there was 42 out of 52 that remained a concern. Out of that, eight are a serious risk. Is that—

Mr Ryan: So, we have made 82 findings of non-compliance in the year to date. So 39 of those were from a reaccreditation site audit, 42 were from review audits, six were from announced assessment contacts and that is a combined total of 82. All those matters are either referred under law to the secretary or her delegate.

Senator SIEWERT: I'm trying to find out where they are listed, but I'll add up those figures later. Thank you, that clears that up. Can I just go back to the five. So you've kept in contact with them, you've worked them through that process, they are reviewed again—

Mr Ryan: Correct.

Senator SIEWERT: This is for the five that have been sanctioned, is their accreditation then removed?

Ms Mond: Their accreditation can be revoked or we can also revoke their 'approved provider' status.

Mr Ryan: And on our side of the ledger, we could revoke accreditation of a home, of one facility, and the department might revoke the approved provider status of the provider. That's the difference.

Senator SIEWERT: You do the home; you do the provider.

Mr Ryan: In residential care. In home care, it's different.

Senator SIEWERT: I'll put some questions on notice around the home care process because we tend to focus on resi care through the process. I want to go the issue of the unannounced visits. Where is that up to in terms of those being progressed?

Mr Ryan: Do you mean unannounced reaccreditation visits?

Senator SIEWERT: Yes.

Mr Ryan: I'll refer that to my colleague Ms Laffan.

Ms Laffan: I didn't hear the question.

Senator SIEWERT: Where are we up to with the new process of the unannounced accreditation visits?

Ms Laffan: The unannounced reaccreditation audits for residential aged care came into effect on 17 March this year. The new arrangements apply to all new reaccreditation applications made from 1 July.

Senator SIEWERT: And how many have been done?

Ms Laffan: That commences on 1 July.

Dr Studdert: 2018.

Senator SIEWERT: They came into effect on the 17th—

Ms Laffan: The legislation came into effect on the 17th.

Mr Ryan: But visits will start on 1 July.

Senator SIEWERT: Last time you were at estimates, you were talking about some of the issues, particularly when the dates were coming up for reaccreditation. How have you resolved those issues?

Ms Laffan: For example, in developing the new arrangements, one of the things that we really wanted to ensure was that consumers were still able to participate. Obviously, if you have a date ahead of time, you can make sure that consumers are aware of that date and are made available. So, we still do have the same arrangements where assessment teams will meet with 10 per cent of care recipients and their representatives, and the new arrangements are going to support consumer involvement both before and during the site audit.

Senator SIEWERT: Sorry, can you say that again?

Ms Laffan: Both before and during the site audit itself. Care recipients and their representatives will continue to be advised of when a site audit is about to occur. The service will know when it has supplied an application to the quality agency, and, at that point, they can let their consumers know that an audit will be upcoming. The notice will include advice that residents and their representatives may provide feedback on a service to the quality agency before the audit and the assessment team during the audit. On commencement of the site audit, providers must take reasonable steps to inform residents and their representatives the audit has commenced. Reasonable steps must include displaying the poster and could include sending an email or a text message. So, for example, if you informed people ahead of time, and a family said: 'Yes, we're interested. Tell us when the assessment team is here,' then reasonable steps would be to contact that family member. Consumers and their representatives will continue to be able to meet with assessment teams during the audit, and providers will need to provide all reasonable assistance to consumers who wish to meet with the assessment team.

CHAIR: How long is an assessment likely to take? Is it hours or days?

Ms Laffan: A couple of days.

Mr Ryan: Two to three days, depending on bed numbers, normally.

Senator SIEWERT: The requirement is that they take reasonable steps. Do you then assess that they've taken reasonable steps to notify—

Mr Ryan: Yes, we certainly do. The new arrangements do place strong requirements on providers to provide the self-assessment, as Ms Laffan has said. They're required to maintain a database under the Accountability Principles of family members or the loved ones that support residents, and they're obliged to inform them that there will be an accreditation audit in the near future at a date that is not specified. You would be aware that the complaints commissioner process as well as our own 1800 number provide many opportunities for any resident or family member who has any concerns to raise them at any time. We will, when we go on site, still randomly select 10 to 15 per cent of the residents to conduct consumer experience interviews. And if there was a family member who was not randomly selected who wanted to speak to us then of course we would do that, and if they were not available to speak at the time we would be happy to speak to them on the phone. And the delegate of the CEO—my delegate—when he or she makes the decision takes onboard a whole raft of information, including what family members or residents have said.

CHAIR: This might seem like a flippant question. I certainly don't mean it that way. But how do you randomly choose the residents? Is it literally that you have an app that randomises the residents?

Mr Ryan: We still have a human for that process.

CHAIR: But there might be a tendency to choose the least-vulnerable people?

Mr Ryan: It would be completely random. We select them from a list of residents, randomly. We would say that we'll take every eighth in order to reach our 10 per cent. We randomly select them, not the provider. And of course some residents or family members want to speak to us but in order to determine those consumer experience reports we publish that information. We only include the feedback from the randomly selected ones in the compilation of the consumer experience reports, but any other information we gather on site from family members or from residents is gathered in the information that informs the final decision-maker.

CHAIR: Thank you.

Senator SIEWERT: So, the upshot of all that is that you do actually, during the audit, audit whether they've done what they said they were supposed to do in terms of informing their residents?

Mr Ryan: Yes.

Senator SIEWERT: Okay. I want to go to the Commonwealth home care program and the talk about maybe merging the Commonwealth homecare packages and the homecare packages.

Ms Beauchamp: The Commonwealth Homes Support Program?

Senator SIEWERT: Yes, and the home care—

Ms Beauchamp: No decisions have been made.

Senator SIEWERT: Well, that's what I want to ask about. Is it something that's being seriously considered? And I'm not passing comment; I'm just asking whether that's something that's being actively still considered.

Ms Grinbergs: It is something that remains under consideration, and we're continuing to undertake work in that regard. As you'd be aware, we issued a consultation paper last year.

There were responses to that consultation paper and they've been published on our website. We've also been engaging with a NACA advisory committee on propositions around how you might—some of the considerations around integration of Commonwealth Home Support and the Home Care Program. We've only just received that report from the NACA advisory committee, so we haven't had an opportunity to actually consider that yet, and the implementations and suggestions within that. But to a large degree it's consistent with the feedback we had through the discussion paper that while there's agreement on some elements of reform—for example, the need for integrated assessment: there was a measure in the budget about bringing together regional assessment services and the aged care assessment teams over the next two years and agreement around the need for more consumer supports and reablement approaches. So, again there's a measure in the budget around supporting and trialling some improvements for functionality over the next few years, and a precursor to that through the Commonwealth Home Support Program. There continue to be very differing views on how services should be funded, and there is no consensus on a preferred funding model for an integrated program. So, we continue to explore in those areas.

Senator SIEWERT: Is there in-principle support for the government on this? Or you haven't even got that far in terms of the merging of the two programs?

Senator McKenzie: I think it would show that it is an issue worth exploring. Obviously that work is being done, but no decision has been made.

Senator SIEWERT: Not even at the in-principle stage?

Senator McKenzie: No.

Senator SIEWERT: Are you working for a time frame for when government will have the information in which to make that decision?

Senator McKenzie: Yes. Well asked.

Ms Buffinton: As a minimum, we know that Commonwealth Home Support has been extended to 2020. So that's the minimum.

Senator SIEWERT: We could consider, therefore, that that's still the time frame and that you are working to that time frame.

Ms Buffinton: It's a minimum. Commonwealth Home Support has been extended to 2020.

Senator SIEWERT: I have some more questions on that that I'll put on notice. I have questions about accessibility on My Aged Care in terms of accessibility to information. I've had constituents' feedback on accessibility in terms of being able to access information when, for example, you have a visual impairment.

Ms Buffinton: My Aged Care, as we know, is both the website, contact centre, assessments and referral service. Part of the reason why we have both modes of a website and a contact centre is preferencing, so people can ring a contact centre rather than reading things on a website. But on all of our websites we follow government guidelines in terms of accessibility. For example, we choose to put our information at a level of grade 5 in terms of understanding of information. I might have to take on notice exactly whether there is voice recognition on the website. It is something my colleagues will know, but I haven't got the details here.

Senator SIEWERT: Could you take that on notice, and if there is, when that function was put on the website?

Ms Buffinton: Certainly. In terms of accessibility more broadly, we redesigned the website. I don't know whether you are aware that in April we relaunched the website. We have had quite strong feedback. We set the website up in 2013 as best endeavours, but people did note that they felt that it needed a fairly strong command already of the aged care system to really navigate the old website.

Senator SIEWERT: I think that is a fair analysis.

Ms Buffinton: We put a lot of work in, did a lot of user testing and so forth. Now when you go on to the website, it's a much simpler page. It covers four key domains. Are you coming in for general information; are you already on the journey; are you selecting a provider? We have also colour coded—so you may be aware and hopefully in your offices you have the booklets—we have Commonwealth home support, home care and residential, so we are colour coding the website to all the materials so people can follow a colour of what program they're involved in. Then in the budget this year we have additional money to now make a website that starts being interactive. So depending on what you've provided—sometimes everybody finds it a bit creepy when you go searching on websites, but it is starting to intuitively understand what you're looking for, with the ability to interact and eventually suggest to help people through their journey of whatever aspect of aged care they're looking at.

Senator SIEWERT: I did see that. Can I ask you to take on notice how you have addressed the issues of accessibility in the new website. That would be fantastic, thank you. Is it possible that we could get a briefing on the new set-up for the new quality and safety commission?

Ms Beauchamp: We can do that through the minister's office.

Senator SIEWERT: Although we have run out of time now, it would be pretty good for the committee to get a good understanding of how that's developing.

Ms Beauchamp: Absolutely.

CHAIR: This concludes the examination of the Health portfolio. I thank the minister and officers for their attendance. Senators are reminded that all written questions on notice should be provided to the secretariat by 8 June. Officers are reminded that answers to questions taken on notice should be returned by 16 July.

Committee adjourned at 23:00