COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON PETITIONS

Reference: Petitions presented before 14 November 2008

WEDNESDAY, 3 DECEMBER 2008

CANBERRA

BY AUTHORITY OF THE HOUSE OF REPRESENTATIVES

[PROOF COPY]

[10.18 am]

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CULLEN, Professor David, Acting Assistant Secretary, Policy and Evaluation Branch, Department of Health and Ageing

FLANAGAN, Ms Kerry, First Assistant Secretary, Acute Care Division, Department of Health and Ageing

PRIMROSE, Dr John, Senior Medical Adviser, Pharmaceutical Benefits Division, Department of Health and Ageing

STUART, Mr Andrew, First Assistant Secretary, Ageing and Aged Care Division, Department of Health and Ageing

YAPP, Ms Gail, Assistant Secretary, Acute Care Strategies Branch, Acute Care Division, Department of Health and Ageing

CHAIR—Welcome. Although the committee does not require you to speak under oath, you should understand that this meeting is a formal proceedings of the parliament. Giving false or misleading evidence is a serious matter and may be regarded as a contempt of the parliament. I will start off the questions and then hand over to other committee members. We will go first to the petition from the Naval Association of Australia about palliative care and hospice accommodation for war veterans on the Sunshine Coast. Can the department provide some advice on the extent of its support for programs for veterans in terms of palliative and hospice care and whether it has any plans to consider extending or expanding its involvement in this area?

Mr Stuart—Yes. The division of responsibility on palliative care between the Commonwealth and the states is that the state and territory governments are the funders and organisers of palliative care in hospitals and in the community. The Australian government's role, though the National Palliative Care Program, is to develop strategies for improvement in palliative care in all the states and territories. Examples of the kinds of activities that the Commonwealth undertakes are that we fund the Palliative Care Knowledge Network at Flinders University, with a website and a one-stop shop with palliative care information; we do guidelines for palliative care approaches in residential aged-care homes; we do guidelines for palliative care in a community setting; and we have a program of funding to Palliative Care Australia to develop and promote a national standards assessment program and so on. So they are of the nature of practice improvement, information, help and training type programs. The actual responsibility for the level of provision of palliative care on the Sunshine Coast would be the responsibility of the Queensland government.

CHAIR—Do any committee members want to ask any further questions on that particular petition we have before us?

Mr ADAMS—I have some questions. The delivery of palliative care goes to the need for nurses to be able to provide drug therapies. Is that part of this knowledge base and laying down the guidelines—the issue of making sure that nurses can deliver the drugs necessary for someone in palliative care?

Mr Stuart—It is not an area where I have a great amount of expertise, but what I can tell you is that there is an expert group on palliative care medicines that is managed by the Department of Health and Ageing. That provides clinical and technical support to the department on how to improve access to, and quality use of, medicines in palliative care, especially palliative care in the community.

Mr ADAMS—Okay. If I just tell you where I am coming from, I did have a situation in my electorate where, because a doctor was away and no nurse had the 'tick' to deliver the care, they had to shift somebody about 40 kilometres, and therefore a person died without their friends around them. That caused a fair bit of angst, because the community thought it was a pretty poor effort—and so did I—that it had to rely on a medico doing it when there were plenty of nurses who could have done the job but who needed the tick. Is anything being done in that area that we could advise these petitioners?

Mr Stuart—I am unsure of exactly what the cause of the problem was.

Mr ADAMS—The problem is that it is controlled by the medical profession—the delivery of drugs, say morphine, to somebody to ease the pain of dying. One of the things about dealing with people who are dying in my experience is that most people would like to die without pain and with somebody there. I should imagine that that would be in your guidelines that are being developed. Not having to shift somebody away from their family, and giving the opportunity for nurses to deliver the drug therapy, I would have thought, would have been a major process that we could be working towards. Maybe you could take that on notice.

Mr Stuart—I will take that on notice. I will ask some more questions. Certainly I am aware that one of the issues about palliative care is that people have, sometimes, written documents about what their preferences are—they prefer to stay at home and so on—and then they end up in an ambulance and then end up in a hospital and their preferences are not necessarily communicated.

Mr ADAMS—And they are very ill. So getting these things in some order will take some effort and you can see that the department is endeavouring to do that. But I do not seem to get much of that across my desk in giving me a direction of where things are so that I can advise my communities or anything like that. Maybe there is an opportunity for us to do more there.

Mr Stuart—I will follow that up.

Mr BROADBENT—I do not know who I am asking this question of, but how many inquiries do you get for Commonwealth support for housing care?

Mr Stuart—We do get a few. Not all that many. I think most people understand the division of responsibility between the Commonwealth and states in this area. As I have said the states are responsible for providing palliative care. The Australia government funds the practice

improvement program so from time to time we do have to refer people back to state and territory governments to actually develop palliative care services. One of the things to comment on in this area is that it really is important for palliative care service delivery to be part of a wider health network in state and territory governments rather than to be one-off and local efforts, because they get much better backup and professional support and sustainability that way. That is one of the issues, I think, for communities.

Mr BROADBENT—Aren't we the biggest funders of palliative care through the medical benefits scheme and the Pharmaceutical Benefits Scheme and does the department have an idea how much money the Commonwealth government spends on palliative care through medical benefits and pharmaceutical benefits?

Mr Stuart—Not here today.

Mr BROADBENT—I think you are all in, but is that the wrong question?

Dr Primrose—In terms of pharmaceutical benefits expenditure on palliative care we do have a dedicated palliative care section in the schedule so we have that data in terms of expenditure quarantined and we can provide that quite readily. Of course we also have a lot of the drugs that are used in palliative care—that is, the narcotic analgesics—available on the general part of the schedule. Obviously these can be used for postoperative pain or chronic pain conditions as well as for palliative care, so we could not dissect out the exact proportion of that but we could certainly give the total expenditure, say, on narcotics.

In terms of Medicare benefits, apart from perhaps the implantation of infusion pumps, say, I think that most of the Medicare services would be consultations, but of course that is a huge number for almost any health condition you care to name, so we could not really provide an accurate estimate of Medicare benefits utilisation.

Mr BROADBENT—Who pays the people when they go into a palliative care hospital? Do we?

Mr Stuart—Those palliative care hospitals would generally be state and territory run. Of course, the Australian government makes a contribution to hospital costs through the health care agreements but the management of hospitals, including hospices and so forth, is the responsibility of each state.

Mr ADAMS—There is a growing issue about stand-alone hospices and issues about costs and things. Can you give us any information on that that we could give to the people who are petitioning us about these costs?

Mr Stuart—I do not have any to hand.

Mr CHESTER—Andrew, in relation to the minister's response referring to the Australian government funding a range of projects nationally to support palliative care, is it our responsibility at a federal level to do the demand monitoring or the demographic modelling to find out where these services are lacking, or is that something that the states do themselves?

Mr Stuart—Again, regional service planning would be a state and territory responsibility.

Mr CHESTER—The other reference in the minister's response suggested that states and territories are generally very active. Does that suggest that some states are particularly good and others are not so good? I do not expect you to comment on which ones are not. Have we got national standards?

CHAIR—I do not think the department—

Mr CHESTER—I do not expect you to comment on which ones are better or worse, but do we have varying standards across Australia in that regard?

Mr Stuart—What I would say is that there is a significant appreciation across the country as a whole of the importance of palliative care, and it has been a growing agenda over the last few years—reflected also in the Commonwealth government's palliative care strategy. So I would say it is a very active agenda across Australia.

Mr CHESTER—And does that strategy set national standards of what is expected through palliative care?

Mr Stuart—There are guidelines, but I do not believe we have national service standards.

Mr CHESTER—So it is not, for example, linked to a COAG funding agreement: 'This is a standard you will achieve,' linked to funding'?

Mr Stuart—Not specific to palliative care, no.

Mr ADAMS—Is there any work going on in that area to lift the standard?

Mr Stuart—The work that is going on to lift the standard is the kind of work that the Australian government is investing in, which is a knowledge network, a website, guidelines for practitioners and guidelines for nurses. One of the issues about palliative care is, as you have alluded to, that people get whisked away in ambulances at the first sign of trouble, rather than having their choices honoured. At times that can happen. The benefit of training and guidelines is to give practitioners confidence that they can honour people's choices without in any way breaching professional codes. So we have been putting a fair bit of effort into that kind of thing.

Mr BROADBENT—How many people in the department are actually working on the research and development of these policies? Have you got a palliative care section?

Mr Stuart—We do have a palliative care section and it is of the order of 10 people.

Mr BROADBENT—And are they looking to where we are headed with palliative care across the nation?

Mr Stuart—Yes, absolutely.

Mr BROADBENT—And has any sort of report come through at this stage as to where we are at and where the department and the government are headed?

Mr Stuart—I could certainly provide you with a copy of a palliative care strategy from the Australian government.

Mr BROADBENT—All right. So there is a strategy?

Mr Stuart—There is a strategy, and at some stage, no doubt, it will be evaluated. But again I do not have specific information on that.

Mr BROADBENT—No, that is all right. I am just interested to know whether we are actively involved in palliative care. From what you are telling me, Andrew, we are. I would like to know to what extent we are involved and where it is headed. Is that headed, as Mr Chester advised, for COAG? Will it just stay within the department? Is it just guidelines for the minister?

Mr Stuart—We are involved in funding service improvement initiatives and we are cooperating with the states and territories on that.

Mr BROADBENT—So we are actually giving the states money to improve their services?

Mr Stuart—No. As I have said we are developing tools, guidelines and things of that sort.

Mr BROADBENT—I am sorry—I misunderstood. I was not trying to lead you astray. I just wanted to know how involved we are.

Mr Stuart—I was just looking for a figure on our total investment but I think it may have been in the minister's letter.

Mr BROADBENT—What is the relationship between that group of people looking at palliative care and pharmaceutical benefits? Do you have contact with that group? Would you like to comment?

Dr Primrose—Most certainly. I am a member of the Palliative Care Medicines Working Group, the one that Mr Stuart mentioned before. I am also on the management advisory board of a project that the government has funded for the palliative care clinical support collaboration, which is a network of academic departments and hospital departments across the country which are cooperating in primary research in palliative care, particularly running randomised controlled trials of drugs that would be suitable for particular indications in palliative care. These are old medications so that it is not possible now for the sponsors to invest the time in running such a research program, but this is being done with government funding. There are up to six trials that are going to be funded through that process which will look at things like relief of symptoms of bowel obstruction, pain control, control of delirium and so on. So this is quite an exciting collaboration and probably puts Australia at the front end in the world for palliative care research and development. In addition, there is another component of the Palliative Care Clinical Studies Collaborative or PaCCSC, which is what the collaborative is called, in terms of looking at quality use of palliative care medicines to promote the highest standards in prescribing of these medicines.

CHAIR—You just mentioned the six trials. Have they started?

Dr Primrose—One of them has. A number of patients have already completed the trial, and of the others—do not hold me to this; this is purely from memory; I was not briefed on this—two have started to recruit and the others are in the final stages of getting ethics committee approval and so on. I am sure the relevant area of Mr Stuart's division will be able to provide more detail.

Mr Stuart—Having found my place I can tell you that the total Australian government funding for those initiatives is $90 million over the next four years.

Mr BROADBENT—Is it possible to get a report from the palliative care working group? Do they produce reports on their progress?

Mr Stuart—The working group that Dr Primrose was talking about?

Mr BROADBENT—Yes.

CHAIR—How often do they meet?

Dr Primrose—We have met every six months. The output of the working group is the palliative care part of the Pharmaceutical Benefits Schedule plus—

Mr BROADBENT—So that is a different working group to the number of people working in Andrew's office?

Dr Primrose—Yes, that is right. It is made up, mainly, of external—

Mr Stuart—I have a section and the section provides support to this working group, of which John is a member. I think the best thing that I can provide you with, if I can find it, is the palliative care strategy. I will provide that to you.

Mr BROADBENT—That would be great.

CHAIR—You can take that on notice and get back to us.

Mr ADAMS—Can you throw any light on the issue of personal care assistants in nursing homes, which is what some of the people are petitioning the parliament on?

Mr Stuart—We certainly can.

Mr ADAMS—I know there are carers and RNs. These are personal care assistants.

CHAIR—There are two similar petitions on that. I think Mr Chester just has a question on the petition that we were just discussing.

Mr CHESTER—Sorry, I have one quick question in relation to the Sunshine Coast, just to draw a line under it, perhaps, for the petitioners' sake. Without being seen to be passing the buck,

would the petitioners be better off directing their efforts towards the state government in this regard rather than to us as the Petitions Committee of the federal parliament?

Mr Stuart—Yes.

Mr CHESTER—So we should be encouraging them to redirect their efforts to that area?

Mr Stuart—Yes, that is right.

CHAIR—We will move to two petitions—I understand they are from the same petitioner—on the funding for personal care assistants in nursing homes and the ratio of personal care assistants in nursing home. It is just different wording. The minister's response mentions increased funding for vocational education and training places, including up to 50,000 of the 450,000 additional places to be allocated to health occupations. Can the department provide advice as to when these places will be delivered? Can the department provide information as to when the exact numbers will be known across different occupations in the health sector, including staff in aged-care homes?

Mr Stuart—The COAG agreement is to deliver the additional 50,000 VET places over three years, from 200-09. This is an initiative of the Department of Education, Employment and Workplace Relations. So the specific rollout is their responsibility but it will take place over the three years from 2008-09.

CHAIR—Mr Adams, I think you had a question on this.

Mr ADAMS—Yes, I have a question on the personal care assistants. What is a personal care assistant, other than a carer? I know about carers and that there are nurse practitioners—

Mr Stuart—They are carers.

Mr ADAMS—They are carers? Is that just another term?

Mr Stuart—They form the majority of the staff at aged-care homes.

Mr ADAMS—I understand: a carer. Is the training we are talking about for more of these people?

Mr Stuart—Yes. Increasingly, carers in aged-care homes have certificate II, III or IV in personal care. They are increasingly highly trained and increasingly professional. This is a further movement in that direction.

Ms GEORGE—In reference to those places, as I understand it they fall under the umbrella of what is referred to as productivity places. Some 54,000 have already been rolled out this year. Could you tell us how many of the total number that have been allocated went to personal care workers? How many are currently involved in training?

Mr Stuart—I will need to take that on notice and see information from DEEWR on that.

Mr ADAMS—Is this the same training for home and community care people who deliver the service in the home?

Mr Stuart—It is related. There would be elements of the training that would be similar. But there are probably specific elements about in-home training versus training for being in an aged-care home.

Ms GEORGE—In reference to the new funding instrument, as I understand it, it kind of leaves more discretion at the local aged-care facility to determine the mix of nursing and personal care staff and resident needs, so there is no kind of fixed standard formulas that apply. You say here that you are going to review the impact of the new funding instrument. Will that review, apart from looking at staffing levels, take into account the word that I am hearing from my providers, which is that it is becoming less commercially viable for them to tender for low-care places? They see this new funding instrument as blurring the lines between funding for high- and low-care bed places. It seems to me that this could become an emerging problem that the department needs to be on top of. I notice that in Queensland and Western Australia some number of places have been handed back, according to the information from the network of employers in the sector. Can you tell us a little bit more about the review and what it will involve and whether what I am hearing is locally is what you are hearing nationally?

Prof. Cullen—There are a lot of questions there. I will try and take them seriatim. I do not think that it is fair to say that the new aged care funding instrument provides more flexibility to providers with regard to their staffing. There was certainly a change in 1997 with the introduction of the previous funding instrument, the resident classification scale, when we moved away from a system called CAM/SAM, the care aggregated module, which had a very specific level of funding and, underlying that level funding, a notional staffing roster. That flexibility was introduced for aged-care providers in the 1997 reforms. The new funding instrument does not provide any additional flexibility there. It is important to note that at the time that flexibility was introduced there was a clear responsibility on approved providers to ensure that they had an appropriate mix of staff to deliver the quality of care that is required by their residents. The flexibilities that were introduced there were about finding efficient ways to deliver quality care, not about reducing the quality of care. That deals with the first question that you asked.

As for the ACFI 18-month review, it will be examining all aspects of the instrument, including whether there has been a shift in high- and low-care and whether the new funding instrument is having unintended consequences. It would be fair to describe the new funding instrument as providing more funding for the most frail residents. Although some additional funding was provided at the time of the introduction of the new instrument, if you provide more funding for the most frail residents then necessarily some residents will be funded at lower levels than what they might previously have been funded at.

That again is a trend that we have seen over a decade. The previous instrument, when introduced, also funded some residents at lower level than that which they had previously been funded at. That fits with the fact that there are now many more community care places available than previously. There are 180,000 residential care places and about 50,000 community care low-care places. Yes, there is a trend towards delivering that low-level care more in the

community and the funding instrument recognises that and therefore concentrates the funding at the higher level of care.

As to whether the aged care funding instrument is affecting the viability of providers, the review will be considering that, but in the immediate term from a, I suppose, purely theoretical position that is not possible in that there are strong grandparenting arrangements in the funding instrument so that no resident can be funded at a lower level under the new instrument than the level they were funded at under the old instrument. When a resident comes up for review and the new instrument says that they should be funded at a lower level, they will not be; they will be funded at the same level. In fact, funding rates per resident this year across the industry as a whole are eight per cent higher than what they were last year—

Ms GEORGE—But if the composition of residents in low- and high-care is changing because more people are ageing in situ long term, you do not have bonds for the high-care places. If they are getting more high-care and frail people and more people at the lower end are staying at home or using community packages, they are telling me that their financial viability is diminished because the proportion of high-care is growing at the expense of people who might historically have come in and paid a bond for a low-care place.

Prof. Cullen—I have heard that argument put.

Ms GEORGE—Are you saying that there is merit in that argument or not?

Prof. Cullen—The most recent benchmark surveys of the industry that have been published show that profitability across the industry increased in the last year over the previous year. That is all I can say about that.

Ms GEORGE—So I will let my providers know that that is the current view of the department.

CHAIR—I understand that we have some people here who can answer questions about the funding of Kempsey District Hospital. We have not received a ministerial response to the Kempsey District Hospital Petition, but that is not due until around 20 January. Do you have any update on how that is progressing?

Mr Coburn—That is in train at the moment.

CHAIR—Fine. Can you advise the committee how matters in the petition are currently being determined by the department?

Ms Flanagan—I will start by indicating that there we receive requests from individual hospitals for funding or for the Commonwealth to intervene. You would appreciate that the states and territories fund hospitals and that the Commonwealth provides funding through the health care agreements. We have not in the past been in the business of funding individual hospitals. That planning, just as Andrew said about palliative care, happens at the state level. However, the government has announced that it has a new infrastructure fund, and there are processes being put in place in order for hospitals to bid for those funds. Damien might give a bit more on that. At COAG on Saturday, a new health care agreement was struck, with significant additional

funding flowing to the states and territories for hospitals and for a range of other services. New South Wales has about $20 billion over five years of that, so it will be able to determine priorities within its own planning processes. I will let Damien also speak about that.

Mr Coburn—Yes, as Ms Flanagan said, up until now it has not really been the usual business of the Commonwealth to provide funding for these kinds of projects, but the government's Health and Hospitals Fund now theoretically provides a funding source for projects such as these. The originally announced priorities for the fund included, for example, refurbishment of major public hospitals.

As you will be aware, the legislation to give effect to the Health and Hospitals Fund is being considered by the Senate. We are, at the moment, developing processes in parallel for how the fund will operate in anticipation of the passage of the bill through the Senate. We will not be able to finalise that, of course, until we know what the legislation is definitely going to look like.

CHAIR—That is right—if it passes!

Mr CHESTER—Kerry, I am interested in the process of receiving petitions in terms of the department. Would this issue have come to your attention before the petition arrived? Were the Kempsey hospital redevelopment needs already on the radar of the department or did this come up through this petition process?

Mr Coburn—I should answer that. We work in different areas. The issue first came to the department's attention through letters to the minister raising the need for funding for Kempsey hospital in the context of the Health and Hospitals Fund. We provided a response which was broadly along the lines that I have just described—that he fund does exist but that the processes are still being established. For example, I wrote to the general manager of Kempsey shire council in those terms in September.

Mr CHESTER—Did the letters come from residents, local people? How did they come to your attention?

Mr Coburn—One came from the general manager of the Kempsey shire council, who wrote to Minister Roxon. I responded on Minister Roxon's behalf. It also came through the local member, who wrote to the minister. Senator McLucas responded to that.

Mr CHESTER—When you receive a petition in the department—I think the one Mr Hartsuyker tabled had 4,000 signatures—do they attract more attention if you see a significant level of support at a local level from the department side of things or is it just another petition and there is no pecking order in terms of how you react to a petition arriving on your desk?

Mr Coburn—We do not particularly have, as I understand it, a process for dealing with petitions as such differently to normal correspondence to the minister. Aside from the need to provide the appropriate response to the Standing Committee on Petitions, it is handled as per ministerial correspondence in the usual way.

Ms GEORGE—My understanding is that there is an allocation of around $5 billion into the Health and Hospitals Fund—is that right?

Mr Coburn—Yes, that is correct. That has already been allocated from last year's surplus.

Ms GEORGE—I could not work something out. I know my university has applied to the education fund and been short listed, so the guidelines have been out for that fund and the infrastructure fund. Is there any reason why they are not out for the health fund? Is it because it is totally new?

Mr Coburn—There are different processes. What is happening at the moment is that there has been an interim process. That is occurring right now. It is in response to the Prime Minister's announcements jointly with Minister Albanese and the Treasurer on 14 October asking ministers to bring forward interim infrastructure statements to government for early drawdowns on the fund as part of the government's economic security package. An interim advisory board was established for the Health and Hospitals Fund and criteria for the interim process were on the internet. If you look at the A-Z guide on the Health and Ageing website under 'h' for Health and Hospitals Fund you will find the criteria.

Just to turn to the legal basis for that, the Nation-building Funds (Consequential Amendments) Bill 2008, if passed, will give the authority to these interim processes for the purposes of the ongoing arrangements of the fund. The advisory board did consider a small number of proposals that were on hand, and they are currently subject to advice to government. The process has been different for the Health and Hospitals Fund precisely because, as you said, it is a completely novel process. It is not building on existing funds, as the education fund and Building Australia Fund are.

Ms GEORGE—But you have not called for public submissions for funds? That is yet to come?

Mr Coburn—That is correct. We imagine that the minister will be doing that in the not too distant future but, in terms of what is happening now, we have not done that.

Mr BROADBENT—There is the funding for the superclinic rollout, the Commonwealth health and hospitals fund and the Commonwealth infrastructure fund. Is that the same thing as the nation-building fund?

Mr Coburn—There are three nation-building funds: the Building Australia Fund, the education investment fund and the health and hospital fund. They are all subject to the Nation-Building Funds Bill. The GP superclinics are a budget measure. There is not a separate nation-building fund.

Mr BROADBENT—So they are all under the nation-building fund?

Mr Coburn—They are under the same legislation.

Mr BROADBENT—And the superclinics are separate?

Mr Coburn—The superclinics are not part of the nation-building fund. That is correct.

Mr BROADBENT—Are they part of the proposed development of a hospital—for example, Kempsey? I thought the superclinics were going into hospitals—or near hospitals.

Ms Flanagan—We would need to take that notice. I do not think we have here today the people who know where the superclinics are being located.

Mr Coburn—Broadly speaking, the superclinics are not necessarily part of hospitals. They are primary-care facilities. They are in a quite separate program. It would be only coincidental if they were co-located with hospitals.

Mr BROADBENT—But they are to relieve hospitals?

Mr Coburn—That is one of the broad policy objectives.

Mr ADAMS—I have a question regarding the Kempsey hospital. Is this a trend—that people are retiring to the coast and putting pressure on some of these hospitals and they then need to upgrade them? Is that one of the issues that emerges from this?

Ms Flanagan—All states and territories have capital plans. I know that New South Wales has a plan for five or 10 years out, whereby they take into account where their population is moving and what sorts of services might be required. We all know that we have got an ageing demographic on the North Coast of New South Wales and in the southern part of Queensland, and you do not need facilities to cope with that population. New South Wales would certainly have that in their planning processes.

Mr ADAMS—But it takes a long time to realise that. The demographics are changing a lot quicker than they ever used to, and that changes the whole dynamics of health delivery.

Ms Flanagan—It can do but, if they are doing medium-term planning, they can have an informed view of what might be happening in those areas. We see not just the ageing of the population but also young people being attracted to those areas as well. So you need to think about child health services and maternity services as well as services for older people.

Mr ADAMS—Northern New South Wales has had a lot of population change in the last 10 to 20 years. It has demographically change. We politicians know that those demographic changes have changed the political landscape considerably. On my reading of it, the planning could have been a bit better. I agree with you that a lot of different dynamics are operating their with young people. I know there are people with heart conditions who need to go to Queensland or come back to Sydney. I remember that postnatal depression issues were quite big in northern New South Wales.

Mr CHESTER—I appreciate that you have not formally called for submissions under the Health and Hospitals Fund, but for the comfort of the petitioners here, have they come to the right place in terms of where their petition has been tabled? Will they be considered as part of that process or will there need to be a formal process going forward on the Health and Hospital Fund?

Mr Coburn—They will need to apply formally. I cannot specify the exact processes, but most likely it will be through the New South Wales Department of Health

Mr CHESTER—For the comfort of the petitioners, it is not unreasonable for them to be coming to the federal government at this stage, saying, 'We've got a project for you', is it? They will then have to go through the processes.

Mr Coburn—It is not unreasonable but the process will be governed by a further process.

CHAIR—Thank you.

[11.00 am]

LEARMONTH, Mr David, Deputy Secretary, Department of Health and Ageing

PRIMROSE, Dr John, Senior Medical Adviser, Pharmaceutical Benefits Division, Department of Health and Ageing

CHAIR—I will go to the petition that I have in front of me, which is on access to the PBS and Medicare for hyperhidrosis sufferers. The principle petitioner is not here today but she is listening to the broadcast as we speak. Is the department aware of any other correspondence to the minister on this subject, and what is the extent of community views about this issue?

Mr Learmonth—I am not personally aware of any other correspondence. If it is helpful, I can give you a brief overview on where we sit on this issue.

CHAIR—If you could that would be appreciated.

Mr Learmonth—That might help the committee decide where it would like to go on this. Briefly, there are a couple of different types of botulinum toxin. There is Botox and there is Dysport, each being manufactured by different companies. They are subsidised on the PBS for four indications in total. Hyperhidrosis is not one of those, but they are subsidised on the PBS for a range of other indications. On the Medical Benefits Schedule, the MBS, injection of Botox is funded for hyperhidrosis. It is not an item that attracts a lot of services—there were some 342 of those in the 2007-08 financial year under item 18362. More broadly, in terms of access to prescribing both the MBS and PBS items, there is a registration process for specialists that came out of a review of botulinum toxin in 2002 with the profession. Having regard to various safety and quality concerns and risks that the profession considered at that time, along with the department, a registration process was put in place where those who wished to have access to the MBS or the PBS items for botulinum toxin had to be registered under the section 100 program, which meant that they had to be one of certain specialties and they had to demonstrate certain experience the with the product. The specialties that have access to botulinum toxin in the MBS and who can prescribe it are in fields such as neurology, public surgery, rehab and orthopaedic head and neck specialists. We have received a request for dermatologists to get access to the MBS for hyperhidrosis, and we are in the process of consulting with the profession about whether they should be added to the list.

CHAIR—When do you think that decision might be made?

Mr Learmonth—Hopefully, fairly soon. It has been going on for a while. They raised it some time ago.

CHAIR—When we say ‘a while’, how long ago is that?

Mr Learmonth—The dermatologists raised it in November 2006 and we then went out to the relevant colleges and to the AMA. At the end of 2007, we prompted them. We still have no formal response from the colleges. We have some individual response and there have been

mixed views on it. Very recently we have had a reply from the AMA supporting the dermatologists. They provided some literature which demonstrates that other professions are using botulinum toxin in this context but they have not provided any information as to training or other requirements that we ought to consider in this context in terms of managing the quality-safety risk. So it is something that we are working with at the moment with the profession.

CHAIR—Are there any other avenues the petitioners can pursue to raise their concerns with any appropriate consultative forum?

Mr Learmonth—On the PBS side, as you know, the government is not able to list products on the PBS unless there is a positive recommendation from the advisory committee and that requires an application. As far as we are aware, there is no application contemplated by Allegan, the manufacturer of Botox, and there have been discussions with Dr Primrose in the last few weeks. If they were interested, as we do for others, we would help them to make a submission but it does require them to do that. On the MBS side of things, as far as I am aware, and I stand to be corrected, the only impetus to change so far is from the dermatologists, who have access to the MBS item, and that is already in process. We are engaged with the profession on that.

CHAIR—Any questions on this petition?

Ms GEORGE—From what you were saying, until such time as the manufacture of the product actually makes the application to the committee for consideration, the concerns of the petitioner cannot be satisfied?

Mr Learmonth—In relation to the MBS, they are being considered. And in relation to the PBS, the way it works is an evidence based cost-effectiveness test. Applications are not restricted to the manufacturer, people can make an application, but it is usually manufacturers who have access to data and utilisation and the effects of the product in order to make a compelling case to the committee. The petitioner is probably best served talking to the manufacturer. We would help and support that process to the extent we can. We are happy to do that but it really is up to the company.

Mr ADAMS—Is part of what we are talking about the excessive sweating under the armpits? Perhaps Dr Primrose can answer that. Is that a quality of life or an inconvenience issue as well as a medical issue?

Dr Primrose—Yes.

Mr ADAMS—That is a new phenomenon that the PBS is confronted with on these issues.

Mr BROADBENT—And hands too.

Dr Primrose—I could give a brief medical perspective on it. We are talking about severe axillae hyperhidrosis. It is quite a serious medical condition so it would meet the criteria of clinical need that the PBAC would address for any future application. We are talking about people who have very excessive sweating and drenching, so the social issues are the stigma attached with permanently wet clothing and of course the odour. But in terms of medical complications, these can be quite serious because people get a skin rash in the armpits and skin

becomes macerated, as you can imagine, with constantly wet skin and can get abscess formation and the infection becomes eventually resistant to antibiotics.

If botulinum toxin does not arrest this process then people have to be considered for surgery. The first line of surgical treatment is usually surgical attack on the sympathetic nervous system that supplies the armpits, and if that does not work then the people have to have a dissection of the axillae that would remove the axillary sweat glands, which is quite major surgery because there are a lot of large number of blood vessels and nerves in that area. Sometimes people have to have surgery even earlier than that to remove infected and diseased tissue under the arms. It is quite a serious medical condition and we do not underestimate it by any means.

Mr Learmonth—The PBAC takes into account those social and psychological impacts on patients in determining the benefit. The minister recently improved the transparency of the PBAC by forward publishing the agendas and allowing consumer input. So the other avenue for petitioners would be that, if the company were persuaded to apply, the consumers can also put forward their own submission to the PBAC and have it considered in conjunction, as part of that.

Ms GEORGE—I was not aware of that. So it does not have to just come from the manufacturer?

Mr Learmonth—It does not have to. They will have the data. But if the manufacturer does, the consumer group or whoever it may be can also put in a supporting statement and have it considered, so there is another avenue for them to express a view in the process as well—directly in that case.

[11.11 am]

BRYANT, Ms Jennifer, First Assistant Secretary, Population Health Division, Department of Health and Ageing

HART, Ms Virginia, Assistant Secretary, Drug Strategy Branch, Population Health Division, Department of Health and Ageing

HARTLEY, Ms Margaret, Principal Scientific Adviser, Office of Chemical Safety and Office of Health Protection, Department of Health and Ageing

LEARMONTH, Mr David, Deputy Secretary, Department of Health and Ageing

THOMAS, Mr George, Director, Treaties and Compliance Section, Department of Health of Ageing

CHAIR—I want to ask about the prohibition of the drug khat. A petition on that was presented in the House of Representatives on 22 September. On 30 October we had a public hearing in Melbourne at which the principal petitioner and other petitioners appeared. To date we have not received a ministerial response to the concerns of the principal petitioner. Can you let us know the progress of that response?

Ms Bryant—A response has been prepared and is with the minister for consideration, but as of this morning we have checked and it has not been signed.

CHAIR—So you cannot assist us in any way to advise the principal petitioner whether there is any existing government policy on this issue?

Mr Learmonth—We can certainly give you an overview about where it sits and how it is being dealt with.

CHAIR—I would greatly appreciate that, if you could.

Mr Learmonth—Certainly. Perhaps I will start off by giving you a broad review. Khat is regulated in a number of ways. It is regulated both at the Commonwealth and at the individual state and territory level. There are some active ingredients in the plant that are recognised in the states' drugs and poisons legislation, but the plant itself is not a prohibited item in all states. Its use is principally limited to males in the Somalian community, so there is a certain geographical association with the issue. At the federal level, the regulation is that we control import under the Customs (Prohibited Import) Regulations. We issue import licences and permits for importation by individuals only, to a maximum of five kilograms per month and for personal use only, not for resale. The permits are issued only in circumstances where that use would not breach relevant state or territory legislation. There are no specific prohibitions on the personal use of khat in Victoria, New South Wales and Tasmania. Other states and territories, in various ways, effectively prohibit khat, including Queensland, which placed controls over the plant on 1 June this year.

Most of the issues associated with khat are about personal use and so on, which is really the province of the states and territories part of the regulation. The Commonwealth only looks at the import side of things. I can say that it is something which is on the radar of the joint Commonwealth, state and territory Intergovernmental Committee on Drugs, which has both health and law enforcement agencies represented. It is something which is discussed from time to time, as it was back in September.

The only other thing I could provide would be a bit of international context. It was assessed by World Health Organisation Expert Committee on Drug Dependence in 2006. That committee concluded that the potential for abuse and threat to public health was not significant enough to warrant international controls. It did not recommend scheduling of khat in UN drug treaties, but it did recognise that there were some social and health problems from excessive khat use and suggested that educational campaigns were the appropriate response. That said, several countries have taken unilateral action to prohibit khat imports. They include the US, Canada, New Zealand and some European countries. Perhaps I will leave it there.

CHAIR—I am just going to pass over to Mr Broadbent.

ACTING CHAIRMAN (Mr Broadbent)—Do you want to ask a question, Mr Hawke?

Mr HAWKE—In relation to the import licences, do you have data on how many licences are—

Mr Learmonth—We do. We have data going back 10 years or so. We could provide that.

Mr HAWKE—Is there a trend? Is there an increase?

Mr Learmonth—There is a fairly significant trend. It started off—I suspect 1997 was a relatively partial year—in the four figures, in the thousands and so on, back in about 1998. I think you would have to say that there was a significant escalation in the last four years or so. In 2004 there had been more or less steady growth since 1998 up to about just under 10,000 kilograms per year. It then almost doubled in 2005 and it is now standing at just over 20,000 kilograms in 2008.

Mr HAWKE—Forgive my ignorance. It is five kilograms, and that is not the plant but the processed material—the leaf?

Mr Learmonth—It is the leaves. I am not sure it is processed insofar as it is merely, I think, the leaves that are stripped off. My recollection is that they used to import the whole plant but that there was concern about fungal and other issues associated with the wood, so I believe it is just the leaves now. Ms Hartley might have better information.

Ms Hartley—It is the leaves and the tips of the plant itself, and it is five kilograms per month per 12 month period.

Mr HAWKE—So when you see a trend or a pattern of increase of that magnitude, do you then pass that material to the states to have a look at to see if it is being complied with, if it is for personal use?

Mr Learmonth—I suspect that is part of the reason why it has been on the radar and has been a matter that has been discussed in the intergovernmental committee on drugs—a committee which does have health and law enforcement representation. They are aware of that. Ms Hart might have more information but I think it would be fair to say that we have not yet been presented with evidence from the states and territories that there is a particularly significant problem. But they are certainly actively looking at it. They have asked—and continue to ask—for import information. We understand that—certainly in the case of Victoria—they are looking fairly closely at what some of the community impacts might be. So it is very much actively being considered. They are very aware of the numbers.

Ms GEORGE—I am not aware of the scientific properties of khat, but I guess it is not dissimilar to kava in that it is, in a way, a culturally specific plant of use. My understanding was that the federal government had, in fact, taken quite a proactive stance in terms of the importation of kava. If it is similar, why is there this differential treatment of khat compared with kava?

Ms Bryant—If I can just comment first on the nature of the substance, I think kava has more of a soporific effect whereas khat is more amphetamine like in its effects. Khat causes sleeplessness and agitation and it can also cause aggressive behaviour. There are health concerns in terms of potential cardiovascular and gastrointestinal complications and so on. So it does have a different chemical effect. I guess the observation we would make is that in essence we do not move, in general, to regulate substances lightly, particularly where they are very limited in use. The international evidence is such that they are not scheduled by the UN and so on, and we look basically to advice from states and territories about the impact at a community level. In the case of kava, when we responded to concerns in that area there had been significant concerns raised with the Commonwealth by the Northern Territory in terms of abuse and the impact on Indigenous populations there. So it was a response to concerns raised.

Although we have had discussions with the states and territories in the context of the Intergovernmental Committee on Drugs, I think it is the case that they have not raised with us concerns and sought a regulatory response from the Commonwealth. Although there may be social issues arising from excessive khat use by some individuals, in Victoria in particular, it is not something that law enforcement agencies have yet detected. If they are called out to instances of domestic violence and so on, for example, any association with khat use is not visible to them at this point—they are not recognising it as a phenomenon. That may lie behind the fact that, although they are interested in the data, the growth in importation and those sorts of things—and the reports of the petitioner and other concerned individuals in Victoria—it is not something that they have, in a law enforcement context, detected as an issue.

Mr Learmonth—As Ms Bryant said, these things are a balancing issue. We have had correspondence from a couple of the communities, including the Somalian community. They draw a parallel with kava and oppose any further prohibition. Their argument is that the opposition to it is fundamentally religious in nature and there are historical, social and cultural contexts to this plant. So there are opposing views. I guess what the data suggests is that it is possible that there is actually an emerging trend here and that the nature of its consequences are not yet clear. Victoria does seem to be in some ways the hot spot, in that it has got the overwhelming majority of import, of use and of population. It also has no effective control over it, whereas some of the other states do. It is not alone, of course. But, if the data does suggest

there is an emerging trend and if at the state level the state police and health authorities do start to discern there is an issue, it is of course open to them to move more into line with some of the states which do impose more stringent control. Queensland, for example, this year imposed its own restrictions, on 1 June. It would be open to other states and territories to tighten their regulation if they discern there is a problem in the use of it—or talk about other responses. As the World Health Organisation suggested, it is something that might lend itself best to educational campaigns and support about misuse and overuse. There are a number of possible responses.

CHAIR—I am going to hand over to the deputy chair now to continue with the public hearing today. I think Alex Hawke has a question.

ACTING CHAIR (Mr Broadbent)—Is it on the same subject, Alex?

Mr HAWKE—Yes. On a national level, when we see other countries moving to ban it, do we look at that in our National Drug Strategy?

Mr Learmonth—It is something that we are aware of. I guess it depends on the reasons and why those other countries have moved to do so. Principally we look to guidance from the World Health Organisation and its considered view—and it made that view known in 1996—and our own domestic evidence and policymaking fora, which are the Intergovernmental Committee on Drugs and the Ministerial Council on Drug Strategy. We do have intergovernmental arrangements in Australia that pick up both the health and law enforcement aspects of drugs and are able to look at policy and determine policy from domestic inputs and evidence and look at what international drivers there might be.

Mr CHESTER—I want to pick up a point from you, Jennifer, and from our petitioner. You say that users can become violent or aggressive. I think you said that there can be incidents of aggressive behaviour. Although it has not come to the attention of law enforcement agencies at the moment—as I understand you to be suggesting—are we actively seeking that sort of information from our law enforcement agencies? Are we monitoring it in any way? I would imagine that some of our law enforcement people turning up at a Somalian home for a domestic dispute may have some cultural issues. They might not even know what has triggered the dispute. I am concerned that we are getting evidence from the community and from you about the potential for aggressive behaviour. I wonder what we are doing proactively in that regard.

Mr SIMPKINS—I find it a little odd that we are permitting it and that it is somehow seen as legitimate to import something which has only one purpose and that is to achieve some sort of euphoric state. In this country we have alcohol, caffeine and, unfortunately, tobacco, which are all legal drugs.

ACTING CHAIR—I am sorry, I should not have been drinking that coffee!

Mr SIMPKINS—Yet we are in the situation whereby we are letting something like this be imported—five kilograms a month per person or per licence. It seems incredible.

Mr Learmonth—I will attend to your comments in reverse order. I understand what you are saying, but, as with most things, as we have said, regulation is about a balance of cost-benefit

and hitherto this has been something which has been allowed. The evidence, whatever may emerge, is not something that necessarily suggests a stronger regulatory response yet. It really is not about the use of the drug per se but about its misuse and its overuse. If I could answer Mr Chester's question as well, it is something which is being very actively monitored. As I said, law enforcement bodies as well as health officials are represented on those fora. There is active interest from Victoria Police at the moment in looking at the numbers and trying to understand what the implications are. If the evidence changes, one would imagine there will be a case to do something differently.

I suspect part of the problem with this and with things like aggression, agitation and so on is that if you arrive at a household where those things are being displayed it is very hard to discern what the actual problem is. It is very hard to know, for example, what the evidence is—whether or not these are the primary effects of khat or whether they are a result of a combination of stress and sleeplessness that induces this as a by-product. It is hard to know what else is going on in that household. I suspect it is difficult for people to get a feel for it, but to the extent that it is possible I think our sense is that the state and territory authorities are indeed interested in it. They are monitoring it closely. It is something that we are assessing, and we are assisting with the provision of numbers and the statistics on import and so on. It is something which is actively considered.

Mr HAWKE—Who determined the five-kilogram limit? Was it health professionals who provided that advice of five kilograms a year as a reasonable quantity for personal use?

Mr Learmonth—This was all before our time, but I think it would have been a combination of advice coming out of the state, territory and Commonwealth forum and it would have included health input as well.

Ms Bryant—There is a committee called the National Coordinating Committee on Therapeutic Goods which considered this matter first in 1997. The coordinating committee is a policy subcommittee under the Health Ministers Advisory Council. It is chaired by the National Manager of the Therapeutic Goods Administration. Its membership comprises the head of drugs and poisons control areas in each jurisdiction. They considered it and formed a view as to the appropriate amount to be set for import permits.

Ms GEORGE—The way you described its symptoms and impacts, does it have similar properties to amphetamines in general? I am asking this because of the things you said about people being aggressive, and sleeplessness.

Mr Learmonth—It is. They are quite similar symptoms to amphetamine type stimulants—agitation, sleeplessness and nervousness.

Ms GEORGE—Would that not cause a few alarm bells?

Mr Learmonth—Again, I think it is a question of degree. It is a product of misuse rather than use.

Ms GEORGE—Did you say earlier it is five kilograms a month that people can import?

Mr Learmonth—I guess it depends how much they ingest at any given time—how much of it they actually use.

ACTING CHAIR—We might come back to this topic in six months time for another talk. I think that would be good.