



COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Estimates

WEDNESDAY, 1 MARCH 2017

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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Wednesday, 1 March 2017

Members in attendance: Senators Bilyk, Carol Brown, Dastyari, Di Natale, Duniam, Farrell, Griff, Hinch, Kakoschke-Moore, Leyonhjelm, Lines, McCarthy, O'Neill, Polley, Reynolds, Rice, Siewert, Singh, Smith, Sterle, Urquhart, Watt, Xenophon.

HEALTH PORTFOLIO

In Attendance

Senator Nash, Minister for Local Government and Territories, Minister for Regional Communications and Minister for Regional Development

Whole of Portfolio

Mr Martin Bowles PSM, Secretary

Professor Brendan Murphy, Chief Medical Officer

Dr Tony Hobbs, Deputy Chief Medical Officer

Ms Alison Larkins, Deputy Secretary, Chief Operating Officer Group

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

Mr Andrew Stuart, Deputy Secretary, Health Benefits Group

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

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

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

Dr Margot McCarthy, Deputy Secretary, Ageing and Aged Care

Mr Matt Yannopoulos, First Assistant Secretary, Portfolio Investment Division

Mr Craig Boyd, Chief Financial Officer, Portfolio Investment Division

Mr Charles Wann, Chief Budget Officer, Portfolio Investment Division

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

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

Ms Jodie Grieve, Assistant Secretary, Business Capability and Campaigns Branch, People, Capability and Communication Division

Ms Donna Moody, First Assistant Secretary, Health State Network Health State Network

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

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

Mr Daniel McCabe, First Assistant Secretary, Information Technology Division

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

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

Mr Barry Sandison, Director, Australian Institute of Health and Welfare

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

Outcome 1

Ms Bettina Konti, First Assistant Secretary, Digital Health Division

Mr Graeme Barden, Acting First Assistant Secretary, Research Data and Evaluation Division

Ms Natasha Cole, First Assistant Secretary, Health Services Division

Dr Andrew Singer, Principal Medical Adviser

Adjunct Professor Debra Thoms, Chief Nursing and Midwifery Officer

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

Mr Tony Krizan, Executive Director, Research and Operations Group, National Health and Medical Research Council

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

Outcome 2

Mr Jaye Smith, Acting First Assistant Secretary, Population Health and Sport Division

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

Ms Elizabeth Flynn, Assistant Secretary, Preventive Health Policy Branch, Population Health and Sport Division

Ms Alice Creelman, Assistant Secretary, Cancer and Palliative Care Branch, Population Health and Sport Division

Mr Chris Killick-Moran, Acting Assistant Secretary, Drug Strategy Branch, Population Health and Sport Division

Mr George Masri, Assistant Secretary, Tobacco Control Branch, Population Health and Sport Division

Ms Lisa McGlynn, Acting First Assistant Secretary, National Cancer Screening Implementation Unit

Ms Bobbi Campbell, First Assistant Secretary, Indigenous Health Division

Ms Kate Wallace, Assistant Secretary, Health Programs and Sector Development Branch, Indigenous

Ms Kate Thomman, Assistant Secretary, Strategy and Evidence Branch, Indigenous

Ms Meredith Taylor, Assistant Secretary, Program, Services and Access Support Branch, Indigenous

Mr David Hallinan, First Assistant Secretary, Health Workforce Division

Ms Lisa La Rance, Assistant Secretary, Rural Access Branch, Health Workforce Division

Mr Damian Tuck, Assistant Secretary, Health Training Branch, Health Workforce Division

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

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

Mr Graeme Barden, Acting First Assistant Secretary, Research Data and Evaluation Division

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

Ms Natasha Cole, First Assistant Secretary, Health Services Division

Dr Andrew Singer, Principal Medical Adviser

Adjunct Professor Debra Thoms, Chief Nursing and Midwifery Officer

Mr Peter May, Acting Chief Executive Officer, Food Standards Australia New Zealand

Dr Trevor Webb, General Manager, Food Information, Science and Technology, Food Standards Australia New Zealand

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

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

Outcome 3

Mr Jaye Smith, Acting First Assistant Secretary, Population Health and Sport Division

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

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

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

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

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

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

Ms Kate Palmer, Chief Executive Officer, Australian Sports Commission

Mr Matt Favier, Director, Australian Institute of Sport

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

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

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

Outcome 4

Ms Maria Jolly, First Assistant Secretary, Medical Benefits Division

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

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

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

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

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

Mr Jack Quinane, Acting Assistant Secretary, Primary Care and Diagnostics Branch, Medical Benefits Division

Ms Penny Shakespeare, First Assistant Secretary, Pharmaceutical Benefits Division

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

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

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

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

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

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

Dr Andrew Singer, Principal Medical Adviser

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

Adjunct Professor Debra Thoms, Chief Nursing and Midwifery Officer

Outcome 5

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

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

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

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

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

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

Associate Professor Tim Greenaway, Principal Medical Adviser, Health Products Regulation Group

Ms Jackie Davis, Principal Legal and Policy Adviser, Health Products Regulation Group

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

Ms Adriana Platona, First Assistant Secretary, Medical Devices and Product Quality Division, Health Products Regulation Group

Mr David Weiss, First Assistant Secretary, Regulatory Practice and Support Division, Health Products Regulation Group

Mr Bill Turner, Assistant Secretary, Office of Drug Control, Health Products Regulation Group

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

Dr Andrew Singer, Principal Medical Adviser
Adjunct Professor Debra Thoms, Chief Nursing and Midwifery Officer

Outcome 6

Ms Catherine Rule, First Assistant Secretary, Ageing and Aged Care Services Division

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

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

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

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

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

Ms Shona McQueen, Assistant Secretary, Home Care Reform Branch, Aged Care Access and Quality Division

Ms Rachel Goddard, Assistant Secretary, My Aged Care Operations Branch, Aged Care Access and Quality Division

Ms Karen Pickering, Assistant Secretary, Home Support Branch, Ageing and Aged Care Services Division

Ms Helen Grinbergs, Assistant Secretary, Ageing and Sector Support Branch, Ageing and Aged Care Services Division

Committee met at 09:05

CHAIR (Senator Duniam): I declare open this meeting of the Community Affairs Legislation Committee. The Senate has referred to the committee the particulars of proposed additional expenditure for 2016-17 for the portfolios of health and social services, including Human Services. The committee may also examine the annual reports of departments and agencies appearing before it. The committee is due to report to the Senate on 28 March this year and has fixed 21 April 2017 as the start date for the return of answers to questions taken on notice. Senators are reminded that any written questions on notice should be provided to the committee secretariat by close of business on 10 March 2017.

The committee's proceedings today will begin with its examination of the health portfolio commencing with whole-of-portfolio and corporate matters and the Australian Institute of Health and Welfare. The committee will then continue with the Department of Health and other portfolio agencies as listed on the program. Tomorrow morning at 9 am the committee will move forward to examine the Department of Human Services, followed at 1.30 pm by the social services portfolio.

Under standing order 26 the committee must take all evidence in public session. This includes answers to questions on notice. I remind all witnesses that, in giving evidence to the committee, they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee, and such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to a committee.

The Senate, by resolution in 1999, endorsed the following test of relevance of questions at estimates hearings. Any questions going to the operations or financial positions of departments and agencies which are seeking funds in the estimates are relevant questions for the purposes of estimates hearings. I remind officers that the Senate has resolved that there are no areas in connection with expenditure of public funds where any person has a discretion to withhold details or explanations from the parliament or its committees, unless the parliament has expressly provided otherwise.

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

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

The extract read as follows—

Public interest immunity claims

That the Senate—

(a) notes that ministers and officers have continued to refuse to provide information to Senate committees without properly raising claims of public interest immunity as required by past resolutions of the Senate;

(b) reaffirms the principles of past resolutions of the Senate by this order, to provide ministers and officers with guidance as to the proper process for raising public interest immunity claims and to consolidate those past resolutions of the Senate;

(c) orders that the following operate as an order of continuing effect:

(1) If:

(a) a Senate committee, or a senator in the course of proceedings of a committee, requests information or a document from a Commonwealth department or agency; and

(b) an officer of the department or agency to whom the request is directed believes that it may not be in the public interest to disclose the information or document to the committee, the officer shall state to the committee the ground on which the officer believes that it may not be in the public interest to disclose the information or document to the committee, and specify the harm to the public interest that could result from the disclosure of the information or document.

(2) If, after receiving the officer's statement under paragraph (1), the committee or the senator requests the officer to refer the question of the disclosure of the information or document to a responsible minister, the officer shall refer that question to the minister.

(3) If a minister, on a reference by an officer under paragraph (2), concludes that it would not be in the public interest to disclose the information or document to the committee, the minister shall provide

to the committee a statement of the ground for that conclusion, specifying the harm to the public interest that could result from the disclosure of the information or document.

(4) A minister, in a statement under paragraph (3), shall indicate whether the harm to the public interest that could result from the disclosure of the information or document to the committee could result only from the publication of the information or document by the committee, or could result, equally or in part, from the disclosure of the information or document to the committee as in camera evidence.

(5) If, after considering a statement by a minister provided under paragraph (3), the committee concludes that the statement does not sufficiently justify the withholding of the information or document from the committee, the committee shall report the matter to the Senate.

(6) A decision by a committee not to report a matter to the Senate under paragraph (5) does not prevent a senator from raising the matter in the Senate in accordance with other procedures of the Senate.

(7) A statement that information or a document is not published, or is confidential, or consists of advice to, or internal deliberations of, government, in the absence of specification of the harm to the public interest that could result from the disclosure of the information or document, is not a statement that meets the requirements of paragraph (1) or (4).

(8) If a minister concludes that a statement under paragraph (3) should more appropriately be made by the head of an agency, by reason of the independence of that agency from ministerial direction or control, the minister shall inform the committee of that conclusion and the reason for that conclusion, and shall refer the matter to the head of the agency, who shall then be required to provide a statement in accordance with paragraph (3).

(d) requires the Procedure Committee to review the operation of this order and report to the Senate by 20 August 2009.

(13 May 2009 J.1941)

(Extract, Senate Standing Orders)

I welcome the minister, Senator the Hon. Fiona Nash, representing the Minister for Health and Aged Care, and also officers from the Department of Health and the Australian Institute of Health and Welfare. Minister, would you like to make an opening statement?

Senator Nash: No, thank you, Chair.

CHAIR: Excellent. We will proceed to questions. Senator Watt.

Senator WATT: Thanks, Chair. Thanks, Mr Bowles and Senator Nash, for coming today—and Professor Murphy. I am not sure if you seen it, but there is a media report today in some of the News Limited papers about the continuous glucose monitoring election promise of the government. The article I have has a pretty graphic headline: 'Aussies at risk of dying in their sleep left in the lurch by broken election promise'. It goes on to say:

MORE than 28,000 Australians go to bed each night—

It is a pretty serious matter—

not knowing if they'll be alive in the morning and the government has failed to honour an election promise that could save their lives.

It continues:

Type 1 diabetes patients are at risk of dead in bed syndrome where their blood sugar levels plunge while they are asleep causing seizures, coma and death.

Last year, during the election, the then health minister pledged to fund continuous glucose monitoring technology for 4,000 children suffering from the syndrome—from 1 January this year. The problem is that without this device parents of children with type 1 diabetes have to get up every two hours each night to fingerprick their child and test their blood sugar levels. I understand that there is about one person dying, on average, each week from this syndrome, so the failure to roll out this technology is quite literally putting lives at risk. How many of these devices have been rolled out to date?

Mr Bowles: This normally comes up in outcome 4. I will get Mr Stuart to talk about some of the progress on this outcome.

Mr Stuart: I do need to correct something—the 1 January date. I am unaware of a commitment to a 1 January start for this program. I believe that a consumer group included on its website the suggestion of a 1 January start. That has not been a government commitment to date. But I can talk about progress with this measure, which is expected to be rolled out quite soon, and which the department and the government have been working very hard on and regard as very important. The process to select the relevant technology has been completed. We—

Senator WATT: Before you go any further, I have a copy of the government's election costings here. It very clearly says that the date of implementation is 1 January 2017. Clearly the government went to the election promising to roll out these very important devices to families from 1 January 2017. It being 1 March today, we are now two months on and nothing has happened. I can table the document.

Mr Stuart: I am unaware that 1 January was a commitment.

Senator WATT: That implementation date was never communicated to the department?

Mr Stuart: I am unaware of that date having been included in a government commitment. We will be interested in having a look at the document.

Senator WATT: It would be a bit of a worry, would it not, if ministers were out there making election commitments, promising to deliver certain things by a certain date, and not telling the department responsible for rolling it out?

CHAIR: Perhaps we can just wait for the officers to have a look at the document you have just tabled.

Senator DASTYARI: Help me understand the process. Is this stuff what normally gets put in the blue book? What is the general process—not with this specifically? You obviously watch elections, you see commitments made, you are in caretaker mode and you start getting things ready, as you should. Could you just explain it for us at a macro level?

Mr Bowles: At the macro level, as you know, when governments go into caretaker mode and elections are called and all the things that go with that, the department does not provide advice to the government and is available to both the government and opposition for factual information. As things progress, we do monitor, as best we can, election commitments through the media and any other mechanisms that exist. We do not have any direct contact on these sorts of issues until after the election result is known. If, as in this case, the government is re-elected, we then go about dealing with the particular election commitments and managing them from there.

Senator DASTYARI: Following on from Senator Watt's question, then: how do you go from something someone said in a speech at some point to what is going to be government policy that you have to prepare for? With an election document like this, does the government re-present that to you? Is it informal?

I just want to get the mechanics right—how something that someone says on the election trail becomes something the department has to do.

Mr Bowles: Once the government is re-elected and ministers are appointed, we will work with the minister on the election commitments. We work through a process, trying to understand the policy intent and looking at the best way to deliver that policy intent.

Senator WATT: What did the government tell you about their expectations for when distribution would commence?

Mr Stuart: The government has been urging all speed throughout the process.

Senator WATT: They have not given you a date?

Mr Stuart: We are at the moment working with the minister and the office towards a date, which will be quite soon. I can tell you about significant progress that has been made. The Medical Services Advisory Committee has selected the kind of product which meets the terms of the election commitment and is effective. The department is in the final stages of negotiating deeds with companies for supply. The systems required to underpin the arrangement with community pharmacists to supply the material are under preparation and expected to be completed quite soon.

Senator WATT: You are saying that, despite the government going to an election and asking people to vote for it partly on the basis, along with other policies of course, that these devices would be distributed from 1 January 2017, the department has never been made aware of that—and in fact no date has ever been set?

Mr Stuart: I will have to take that on notice. There has been a considerable amount of work going on between the department and other agencies in government, and the government itself, over a period of time since the election on how this will be rolled out—and when and with what product. I will have to take that issue of dates on notice.

Senator WATT: Ms Shakespeare, you are involved in the implementation of this?

Ms Shakespeare: Yes.

Senator WATT: Have you ever been made aware of the government's distribution date expectation?

Ms Shakespeare: The government's expectations relating to the distribution date are to have the program rolled out as quickly as possible. But there are a range of activities we need to undertake before that can occur.

Senator WATT: You have never been told, 'This has to be done by 1 January'?

Mr Bowles: Mr Stuart has already taken on notice to go back and have a look at what—

Senator WATT: I know, but I thought Ms Shakespeare might have the answer.

Mr Bowles: I am telling you now that we will take that on notice and come back to you about what we knew about the date of 1 January.

Senator WATT: The fact is that, with an election policy it would happen from 1 January 2017, two months later it is not happening. This is yet another broken health promise from this government.

Senator Nash: That is actually not correct. There was an assumption made. It was not a direct date as you are suggesting. I think it is very important that we just take a breath and look at this. We obviously said, as the government, that we want this to happen as quickly as possible. My understanding is that we are in the final stages of the implementation of this and—

Senator WATT: But you said 1 January.

Senator Nash: Let me finish! It is very early in the day. We are in the final stages of implementation. An announcement will be made shortly. I note that the Danny Foundation themselves have said that they are working very constructively with the minister and they are expecting an announcement shortly.

Senator DASTYARI: Mr Bowles, this defies logic. This is not some offhand comment that was made in a press conference in an election campaign. We are all in politics—sometimes you will say, 'You said this in this interview' or something like that. But this is an extract from their own election policy costing. This is what they took to the election. If there was any basis for looking at what they were going to be delivering based on what commitments were made, you would go to their policy costings first. I mean, this is their document, right? In that, it clearly says that distribution would commence from 1 January 2017. Now, that has not happened. The bit that I am a bit flabbergasted about is not that it has not happened. Things do not happen—there might be reasons; policy can take longer than it should. But it appears to be the evidence from the Department of Health that, up until this morning, the people responsible for this, which include Mr Stuart and others, were not even aware that 1 January was the date. That was the evidence we were given. You are taking on notice whether or not someone else may have been aware, but the people responsible at the top level were not aware of the 1 January date. How can that be?

Senator Nash: I think it is a bit of an odd argument that you put about the date itself.

Senator DASTYARI: It is in your policy document!

Senator Nash: Let me finish with where I am going.

Senator DASTYARI: Let me finish reading what the minister's office emailed me!

Senator Nash: No, you finished that, Senator Dastyari. The department is obviously working as quickly as they possibly can, as is the minister.

Senator DASTYARI: But that was not the question.

Senator Nash: I know, but your obsession around the date really does not—

Senator DASTYARI: It is not our obsession; it is your obsession! You are the one who put it in your policy document!

Senator Nash: Senator, it is only 9.21 am. We have got a long day to go. You had better calm down; you are going to blow a valve.

Senator DASTYARI: I am here until 11 pm. It is going to be wild!

Senator WATT: It does not say that distribution will commence from 'as soon as possible so the department can get it organised, and we will get back to you about a date'; it says from 1 January.

Senator Nash: Senators, I think the important thing here is—

Senator DASTYARI: Senator, I think you should just resign now.

Senator Nash: delivering this as quickly as possible for the people who need it. The department is focused on doing that. The government has an absolute commitment to doing it as quickly as possible, and I think that answers the question.

Senator WATT: I will move on to another topic: preventative health. This is obviously an area where this government have already made very significant cuts. I think, so far, they have cut \$400 million from prevention and another \$1 billion from health promotion. But we were all assured, I understand, by the Prime Minister's recent speech to the Press Club, where he flagged that, despite those \$1.4 billion in cuts, the government will now have a renewed focus on preventative health. That sounds good! Can you give us an indication of what that might include?

Mr Bowles: Again, it is going to come up in a later outcome, so I will not have all of the people here at this stage. Yes, the Prime Minister made that comment in a speech. The department has always been working on a whole range of issues around preventative health measures, from tobacco, to obesity, to activity, to a whole range of issues. We will continue to do that. I am not announcing anything at all. We are the Department of Health and we continually work on that. It is probably best if we come back later on in the relevant outcome.

Senator WATT: We can certainly explore it in a bit more detail there.

Mr Bowles: It will be on later under outcome 2.

Senator WATT: You would be aware, Mr Bowles, that there has been a large debate over a long period of time about whether it is a good or a bad idea to put a GST on fresh produce, and the health consequences of that. I saw that on 20 February the new minister for health said that fresh fruit and vegetables are effectively discounted because fresh food is exempt from GST. Presumably there are some health arguments for that sort of policy position. If the GST exemption for fresh produce like salads, fruit and vegetables were removed, is it your view that that could lead to people eating more junk food?

Mr Bowles: On the issue of GST, I do not have a view. I have not studied the GST implications on anything. That is a job for Treasury. You should ask Treasury.

Senator WATT: But I am asking about health. I am not going to ask about the financial or economic consequences. I am asking about the health consequences of increasing costs of fresh produce as a result of a GST being applied. That would have to have an impact on people's purchasing choices.

Mr Bowles: I am not going to answer questions on hypotheticals around what might or might not happen with GST that I have no knowledge of at all.

Senator WATT: As this debate has been around for a while—I think 12 months ago we were having the same debate about whether the GST would be extended—did your department provide advice to ministers about the health consequences or dietary consequences of applying a GST to fresh food?

Mr Bowles: Again, you are best to ask that of Treasury.

Senator WATT: No, no—

Mr Bowles: Let me finish, Senator. We have not been asked around any health consequences of any policy along those lines. But, again, you need to talk to Treasury about whether that is a policy or not.

Senator WATT: So in the time that you have been departmental secretary—and when was that from again?

Mr Bowles: October 2014.

Senator WATT: There was a whole debate that occurred about whether a GST should be applied to fresh produce. You are saying that, in your time as secretary, your department has never provided advice about the consequences for health or dietary choices if a GST was extended to fresh produce?

Mr Bowles: And, as I have already said, I do not get into the issues of GST. It is not a current policy of the government.

Senator WATT: I am aware of that.

Mr Bowles: So you are better off talking to them about how they would have proceeded along those lines, if in fact they did decide to do that, which they have not.

Senator WATT: So in not asking you and the Health department for advice about the consequences of applying a GST to fresh food—the health consequences or dietary consequences—this government is not interested in what impact a GST on fresh produce would have on whether people eat junk food or fresh food?

Mr Bowles: Senator, that is not what I said. I am not even going to respond to that. That is an unfair question.

Senator WATT: I cannot even get an answer from you about whether you provided advice.

Mr Bowles: That is not what you just said, Senator.

Senator WATT: My three questions—

Mr Bowles: And I said I did not provide advice. But it is not a policy of the current government.

Senator WATT: I am aware of that. I was asking about past advice.

CHAIR: The secretary has provided an answer. Senator Smith, you had a follow-on from one of your—

Senator SMITH: Secretary or Minister, if you go to the coalition's policy called Help Families with Diabetes, the policy makes it very clear that there is no start date. That is correct, isn't it?

Mr Bowles: That is correct. Can I just add that the document that Senator Watt tabled just before is around how the costings were prepared for that particular announcement, not the actual policy document that we work from.

Senator SMITH: You could not cost a policy unless you had a start date that was—

Mr Bowles: That is correct.

Senator SMITH: public, which it was not in this policy document, or hypothetical for the purpose of establishing a costing.

Mr Bowles: That is correct. We do not do those costs.

Senator SMITH: So Labor's attack would have been more credible if they had delivered the policy document which had the start date. They did not. They produced this document, which is not the policy document. There was no start date.

Senator DASTYARI: It is your costings document.

Senator SMITH: For the purpose of establishing a policy costing, the correct thing to do, Senator Dastyari, would have been to go to the election policy.

Senator DASTYARI: It is the one for the daily—

Senator SMITH: Go to the election policy—

CHAIR: Questions and answers. Questions of witnesses—

Senator SMITH: and tell me if there is a start date.

Senator DASTYARI: It is your own policy document. So your own policy documents do not matter?

CHAIR: Thanks, Senator Dastyari.

Senator Dastyari interjecting—

CHAIR: Order! It is not even 10 o'clock!

Senator DASTYARI: That is her line!

CHAIR: Well, it was a great line!

Senator SMITH: Coalition 1, Labor 0 at 9.30.

Senator DASTYARI: How are things looking in WA, by the way?

Senator SINGH: I want to ask some questions regarding the very long overdue announcement last week by Minister Hunt in relation to medicinal cannabis. In particular, I want to ask about this issue of improved access. How many doctors are authorised prescribers for medicinal cannabis and where in the country are they based?

Mr Bowles: I will get Professor Skerritt to talk to this. If we have to go into more detail, we might have to wait until the appropriate outcome, because not everyone will necessarily be here at this point.

Senator SINGH: Let's see how we go.

Mr Bowles: It is in relation to outcome 5.

Dr Skerritt: Currently, there are 23 authorised prescribers in Australia. They are largely in New South Wales, and there are some in Queensland. But we, obviously, accept applications from any state or any potential authorised prescriber on their merits.

Senator SINGH: How many are there in New South Wales and how many in Queensland?

Dr Skerritt: There are 21 in New South Wales and two in Queensland.

Senator SINGH: None in the rest of the country?

Dr Skerritt: No. But remember that we are responsive to applications coming in to us from those clinical groups.

Senator SINGH: So if the doctor is not an authorised prescriber and wants to become one they have to apply through the TGA under the special access scheme category B. Is that right?

Dr Skerritt: No. There are actually two approaches. The first is if a doctor wants to become an authorised prescriber. That means that they do not have to apply on a patient-by-patient basis. They get authorisation for the use of medicinal cannabis for, say, kids with epilepsy or adults with terminal pain or whatever. They can then provide the medicine to a large group of patients without patient-by-patient approvals. That is known as the authorised prescriber pathway. That requires approval by an ethics committee, and then the application comes to us. The second approach—

Senator SINGH: If I am a doctor in Tasmania and I want to become an authorised prescriber of medicinal cannabis, how do I go about that?

Dr Skerritt: You would go to an ethics committee. You would go through the Tasmanian Department of Health and Human Services for advice on how to do that. There would likely be an ethics committee at a major hospital, say, in Hobart or Launceston.

Senator SINGH: Then I would have to go to the TGA?

Dr Skerritt: Then you would go to the TGA. The approval time for authorised prescribers is fairly fast. It is usually about two weeks that an application is complete.

Senator SINGH: Two weeks with the TGA process?

Dr Skerritt: It varies, of course, with the completeness of the application, but it is a fairly fast process.

Senator SINGH: What is the varying time frame?

Dr Skerritt: The variability is the nature of the condition and the evidence provided. As you are aware, there are some conditions for which there is more significant and substantial and less equivocal evidence, whereas for others it would be considered an unusual use, and in those cases we would seek further advice if required.

Senator SINGH: So the quickest time under the TGA part of the process is two weeks?

Dr Skerritt: No. That is not correct.

Senator SINGH: What is the quickest time frame?

Dr Skerritt: Two days. Under special access scheme B, an individual prescriber can apply to us, although there are also state and territory approvals. We have no control over their time frames.

Senator SINGH: I am just asking about the TGA process. You are saying the quickest time frame is two days. The response that is coming from consumers is that it is taking up to six months.

Dr Skerritt: It has taken some consumers up to 18 months because their doctor has not provided the required information. For example, they may have written on the form 'cancer' or they may have written on the form 'medicinal cannabis' without saying, 'This particular medicinal cannabis product at this dose,' which is what is required under our act and regulations.

CHAIR: I want to remind committee members that we do have a program today. The secretary has already referred to outcomes we should be sticking to—

Senator SINGH: I have almost finished.

Senator DI NATALE: Can I also make a comment. I have a long list of questions, along the same lines as you are suggesting, Senator Singh. I am happy—

Senator SINGH: I am almost finished, and we can come back to that other output.

CHAIR: I would prefer to deal with these things under the appropriate outcome. Senator Siewert has questions specifically related to the AIHW.

Senator SINGH: Practicably, the only way that a patient who needs medicinal cannabis is guaranteed to get it today is to go to an authorised prescriber, of which there are 23, in only two states, 21 in New South Wales and two in Queensland, and none in Tasmania, none in South Australia, none in WA, none in the territories.

Dr Skerritt: Your assertion is incorrect.

Senator SINGH: What, you are telling me there are authorised prescribers in other states?

CHAIR: Let the officer answer, please.

Dr Skerritt: If I may answer, the majority of applications are under special access scheme. Special access scheme approvals can be for a suitable doctor in any state or territory. They obviously have to get the approval from the state and territory and from us. As I said, before—

Senator SINGH: Is there a list of those?

CHAIR: You have had your last question, Senator Singh.

Senator SINGH: Is there a list, though?

CHAIR: The officer has answered the question.

Senator SIEWERT: I want to ask some questions of the Institute of Health and Welfare, which I understand is in this. I have two key areas that I want to ask about. One is the report on veteran suicide, so I can get a clear understanding of where it is at and see whether I am correct in my interpretation, if that is okay. My understanding is that this is the first significant report looking at veteran suicide. Is that—

Mr Sandison: Yes, it is the first time we have had a report about that subject.

Senator SIEWERT: My understanding from the report is that you found that for serving men—and it is about men, not women, so I am going to say 'men', because the numbers are too low for women, for a start—

Mr Sandison: The report is about both, but yes, because of the numbers—you are right.

Senator SIEWERT: The summary we are going to talk about is about men, yes. For serving men, it is around the same as for the broader population?

Mr Sandison: In general, across the total population group, yes.

Senator SIEWERT: And, if I understand it correctly, it is in fact lower for Reserves?

Mr Sandison: Yes. The report that we are going to put out later this year actually goes—

Senator SIEWERT: Actually, I wanted to come to that, yes.

Mr Sandison: Really some of the answers will come through that, I think. But the detail will be closer to the middle of the year. We provided an overview, and that was based on the numbers we had, to go through and provide indicative views, and those specific numbers about the total population. The drill-down we will be doing is going into the groupings across the armed forces and with Reserves and who went through Reserves and who went straight out into the general population.

Senator SIEWERT: Will it also be looking at the different parts of the Defence Force or the different services within the Defence Force?

Mr Sandison: To the extent that the data will allow us to go into it—that is what we are working through now. The total number is relatively small, so the more we drill down, the smaller the groups, and the statistics are not viable for us to respond to. So, as we break it up, if we can, we will actually be able to provide some evidence.

Senator SIEWERT: In terms of where the significance difference is—it is for ex-serving men?

Mr Sandison: Correct.

Senator SIEWERT: Can you just take us through your findings there? I realise we do not have a lot of time, but perhaps you could just quickly go through what the highlights of that are, from your perspective.

Mr Sandison: As you would understand, we put out about 150 reports a year, and there was not advice beyond, 'Please appear at your leisure'. So the specific experts for the different groups are across the institute. But the key finding was in the younger age group. I think it was the 18- to 24-year group. That was where there was a differentiation from the general population.

Senator SIEWERT: And that was significant, wasn't it?

Mr Sandison: Yes. I can table the report that was provided late last year and provide that to the secretariat. That has all the detail that we could get to with the data that we had.

Senator SIEWERT: Thank you. What I am also keen to know about is the time frame for the next report. You have just said—and that is what I understood was—

Mr Sandison: The middle of the year, and we are also looking at adding an additional year of data to it, because it only went up to several years ago. We started in 2001 with the dataset, and we are going to add another year to that data, but we have to wait until we get the final information through. It all works on the coroners findings, so we have to be very specific about all the jurisdictions and coroners findings to make sure that we can validate the data we have. It is about a year and a half after the end of a year that we can actually add another year to the series.

Senator SIEWERT: I want to come back to the coroners data in a minute. And I am not trying to put you on the spot, but do you have a more definite date than midyear for when you are going to be tabling?

Mr Sandison: We are working with the Department of Veterans' Affairs. I can take it on notice. But it is going to be June or July.

Senator SIEWERT: Perhaps I can ask then about the coroners data. When this committee did an inquiry several years ago on suicide prevention, some of the issues that came up were

the issues around coroners reports. Are the coroners reports now—and I have asked this of another expert, so I will be interested to hear what you say, and if you cannot comment then perhaps you could take it on notice—up to the point at which you are confident of the data that comes through on suicide and in particular veterans? I have heard that sometimes the coroners reports do not indicate whether someone was a veteran.

Mr Sandison: From the team that did the work—and I can take it on notice about the detail they go through with coroners, but we do not question the coroner's report. The coroner's report gives us a statement of the specifics. If the coroner notes that it was death through suicide, we do not go back through other forms of data to see whether or not that is validated, but I will check on that. We accept that the cause of death was suicide when we get a final report with a confirmation from the coroner.

Senator SIEWERT: Could you check both things: whether there is an indication that a person served in the military and, secondly, the issues around the suicide. That would be appreciated.

Mr Sandison: Certainly.

Senator SIEWERT: Thank you. Next I want to ask about the latest data that was released yesterday on the Indigenous health indicators. It is a range of tables of information.

Mr Sandison: Correct.

Senator SIEWERT: What happens subsequent to that?

Mr Sandison: With our data across the range of reports that we do—and there are quite a few on Indigenous-related issues—we make everything public. So we provide a summary document. If we think it is warranted, we will provide a media release. The data goes up onto our website. Depending on the nature of the data, it might be in various tables or interactive formats. Some of the work that we have done on mental health and drugs and alcohol is far more interactive and allows you to drill down to low levels of population—so, the PHN level from the health side.

For Indigenous issues we also work with the department, as well as with the Department of Prime Minister and Cabinet and other stakeholders, if they are interested, to talk through the data after the report is done. But basically our job is to try and make it as available as possible in various formats. There can be more data that sits below what we put into an actual report, and part of our job is to get that up on the website to make sure that it is available to as many people as possible.

Senator SIEWERT: This latest data is for 2015. Is there any way you can get more recent data up sooner? I know it is a big issue.

Mr Sandison: That is always the big question. In the main, we are working on how we can streamline some of the processes for approvals. But a lot of our data comes from the jurisdictions. You would be aware that we have to go through and get clearances for the data; so while we might bring it together, we actually go through and get authority from all of the data owners or custodians for the use of data.

For some of the data, it takes quite a long time after the end of a financial or calendar year to make sure that it is accurate. Some things we can do within six to 12 months. Sometimes it takes more than a year, sometimes up to two years. And some of the data sets come through

from surveys, so it depends on when the survey itself was done. The data drawn on might be five or six years old, depending on the timing of the survey.

But wherever we can, we try to get the data out there as quickly as possible. We are working on better ways to do that, to make sure that we can get short, sharp bits of information ahead of some of the major reports. The suicide information is probably a good example. The major report is due in the middle of this year—June or July—but we will put out that summary report ahead.

Senator SIEWERT: I have had feedback from a number of organisations about the fact that your people are on their backs to get information in—which is fair enough—but then they do not get access to it and are not able to use it again for a significant period of time.

Mr Sandison: I am aware of that sort of feedback as well and, as I said, we are working on that.

Senator SIEWERT: So there is a possibility—and I am not having a go, by any stretch of the imagination—that you could start releasing some subsets of the data earlier. Is that what you are saying?

Mr Sandison: That is what we are looking to do, to see how we can segment the data into what we can get cleared earlier. But, again, that comes with a challenge, because if you are segmenting you are getting smaller datasets. That comes with a vulnerability about whether or not it is accurate, or whether or not we can actually release it in the smaller-size fields.

Senator SIEWERT: Okay. I understand what you are saying. Thank you.

Senator DI NATALE: I just have a couple of quick questions. I might follow on with the National Aboriginal and Torres Strait Islander Health Plan. That was published in July 2013. Is that right?

Mr Sandison: That is a broader health plan; that will not be here.

Senator DI NATALE: I want to ask you specifically about the implementation plan in a moment, so I do not need details on the health plan. I just wanted confirmation that it was published in 2013.

Mr Bowles: Again, Indigenous health is usually done in the cross-portfolio session on Friday, so I will have to check and get back to you on that.

Senator DI NATALE: Yes, if you could. I was hoping I could ask a few short questions about it now.

Mr Bowles: I do not think anybody will be here yet. I will ask Dr Southern.

Senator DI NATALE: Perhaps I will just go to the point that I would like to make. My understanding is that the National Aboriginal and Torres Strait Islander Health Plan was published in 2013. The implementation plan for the health plan was then published in 2015. Obviously there are a number of concerning issues around the *Closing the gap* report. One of the things that I think we addressed at a previous estimates hearing was whether there was any specific funding dedicated for the implementation of the health plan. I think in previous estimates the answer was no, and I am just wondering whether that has changed.

Dr Southern: That is correct. The implementation plan measures will be funded from the existing Indigenous Australians' Health Program.

Senator DI NATALE: If you have got this implementation plan, why are we not funding it? Why is there not a dedicated budget to fund the implementation plan?

Mr Bowles: It is actually funded under the funds in the Indigenous health plan.

Senator DI NATALE: There is no new money to fund the implementation plan for the health plan. You are just saying we are going to use the existing pot of money in the various program areas to try to fund the implementation plan—is that right?

Dr Southern: That is correct. Many of the measures and the objectives of the implementation plan are wrapped up in existing programs that we have. Either they are expanding—for example, the programs for mothers and babies, and there are a number of objectives around early childhood health and maternal health; those programs were already in existence. They have been expanding and there is funding in the Indigenous Australians' Health Program to fund those sorts of things. What we have been doing in terms of working with the Implementation Advisory Group is to identify the gaps that appear that perhaps do not have committed funding attached to them, but we can fund them through the funds that remain in the Indigenous Australians' Health Program.

Senator DI NATALE: So there is zero funding for the implementation of a plan specifically, but there is funding in the various program areas. However, there are gaps. Not all the areas identified in the plan are funded?

Dr Southern: Not at the moment, but, as I said, there is capacity within the IAHP to identify what things we need to do and there is funding available to take some of those things up.

Senator DI NATALE: It is hardly a surprise we are not making progress here if we have got a plan that says we need to do all this stuff, we do not spend any money on the plan and we just leave it to the existing program areas, and there are gaps right through it and there is no additional dedicated funding to address it.

Senator Nash: I might assist here, because I was the minister responsible for the implementation plan. Refresh my memory if I am incorrect, but I think there is \$3.4 billion overall in Indigenous funding. I think the key thing to remember here is that it did take a while to get the implementation plan finalised, and I thought one of the very positive things about it was that we actually launched it with the Greens and with Labor; it was very much a tripartisan approach to how we would do this, recognising the complexity of it. I do not think it is a fair thing to characterise it by saying that there is not funding available for the implementation plan and that is therefore a negative. There is significant funding available. I think one of the benefits of doing it this way is that it has allowed us to look at the complexities that need to be looked at and all of those social determinants of health and those types of things as part of the overall plan. So I think concern about not seeing a dollar placed against a particular part is probably a bit misguided.

Senator DI NATALE: I will let my colleague Senator Siewert pursue further questions about this on Friday. There will obviously be more questions on this. I want to finish with questions I have asked at Senate estimates hearings over a number of years relating to a global overview of health expenditure. Could you give me the global overview of health expenditure broken down according to major areas—I will let you talk to that—and then tell me how that is tracking in terms of percentage increases?

Mr Bowles: I will just give you rough figures, Senator. In 2016-17 we are budgeting approximately \$90 billion. I will break that up against some of the major issues: the MBS \$22.9 billion, the PBS \$11.6 billion, private health insurance \$6.4 billion—

Senator DI NATALE: Is that just the subsidy?

Mr Bowles: That is the rebate. The National Health Reform hospitals is \$17.9 billion, aged care is \$17.4 billion and there are a range of others that make up the balance of \$90 billion. If I look at the MBS, from 2015-16 to now—we are still talking about budget because obviously we have not finished the 2016-17 year—it is growing by 4.4 per cent. The PBS is four per cent, PHI is four per cent, the hospitals is 4.2 per cent—and that changes as we go out over the forward estimates as well—and aged care is 7.7 per cent.

Senator DI NATALE: So we are talking overall of an increase of?

Mr Bowles: It is 5.6 per cent. Actuals for 2015-16 were about \$85 billion and we are now about \$90 billion. I will just give you the headline figures for 2017-18, 2018-19 and 2019-20. They are \$90.7 billion, \$92.7 billion, \$96.3 billion and, effectively, \$100 billion. They are whole of government, so that includes the DVA components and everything else that goes into the MBS and other payments.

Senator DI NATALE: So it is \$90.7 billion for 2016-17?

Mr Bowles: Yes.

Senator DI NATALE: And then it is \$92.7 billion, \$96.3 billion and \$100 billion over the subsequent years?

Mr Bowles: That is correct.

Senator DI NATALE: That covers it. Thank you.

Senator WATT: Professor Murphy, I would not want you to feel left out here. I have asked you questions at another hearing previously, but could you very briefly remind us: your role is the chief health adviser to the department?

Prof. Murphy: That is correct, Senator. I am part of the department executive. I am the chief medical adviser to the department and government.

Senator WATT: So for any matters of substantial health policy you are someone the department will call upon—

Prof. Murphy: Those that relate to the Department of Health, yes, Senator.

Senator WATT: You would have heard the questions I was asking Mr Bowles about the importance of fresh food and dietary considerations and things like that. As a health expert within the department, is it your view that increased costs of fresh food, whether that be because of the application of a GST or other reasons, could provide an incentive for people to choose other less healthy options if they are not as expensive?

Mr Bowles: Before Professor Murphy—

Senator WATT: My question was to Professor Murphy.

Mr Bowles: Before Professor Murphy answers the question, Senator, I just remind you that I did say we have not provided policy advice on this. It is not part of government policy, so we would not have done any great analysis of this issue.

Senator WATT: I know. I did not ask Professor Murphy whether he had provided advice.

Mr Bowles: You are asking him to answer a hypothetical question.

Senator WATT: No, I am not. I am not asking Professor Murphy whether he has provided advice. Professor Murphy, as the health expert within the department and chief adviser to the department, is it your view that increased cost of fresh produce as a result of applying a GST would discourage people from purchasing fresh food and might encourage them to choose less healthy, cheaper options?

CHAIR: That is very close to a hypothetical, Senator.

Senator WATT: It is not hypothetical. I am asking him for his considered view; I am not asking him about whether he is advising on policy.

Mr Bowles: He cannot provide a considered view in two seconds when you ask a question like that

Senator WATT: He certainly cannot provide a view when he is interrupted by the secretary and the chair of the committee.

Mr Bowles: I am the secretary of the department—

Senator WATT: I know that.

Mr Bowles: and I have already said we have not provided advice on this and I think it is unfair to—

Senator WATT: I did not ask him that.

Mr Bowles: I reiterate: I believe it is unfair to go down this line when we have had no input into anything related to GST.

Senator WATT: Why are you so sensitive about this?

Mr Bowles: I am not sensitive at all, Senator. I am thinking about the process—

Senator WATT: You are interrupting him answering questions. That is how sensitive you are about it.

Mr Bowles: That is your view, Senator.

Senator WATT: Professor Murphy, for the third time?

Prof. Murphy: Senator, I have not studied any specific details around the impact of costs in the Australian context. All I would say is that generally internationally there is evidence that price points do influence dietary choices. To what extent that would apply in any hypothetical policy context, we have not studied it. But there is evidence internationally that cost is a factor in choice of food. That is a general principle that is pretty well known internationally.

Senator WATT: Thank you, Professor Murphy. It was not that hard, was it?

Mr Bowles: I would say that price points actually impact on just about anything we would look at in this space.

Senator WATT: In what sense?

Mr Bowles: We are talking about one particular part. If prices increase demand changes. This is the normal way the world works.

Senator WATT: So copayments would send a price signal as well?

Mr Bowles: Senator, that is unfair.

Senator DASTYARI: But that is your logic, Secretary.

Senator WATT: That is sort of an extension of what you are saying, isn't it?

Mr Bowles: No.

Senator WATT: I was not actually going to ask about that, but maybe we should go there.

Mr Bowles: You can if you wish, Senator.

Senator WATT: Thank you, Professor Murphy. On a different topic, the plain packaging for cigarettes—

Mr Bowles: Senator, this is not in this whole-of-portfolio outcome. I think that is outcome 2, when the experts are here on plain packaging.

Senator WATT: I would have thought tobacco has a pretty broad-reaching impact.

Mr Bowles: It is part of outcome 2.

CHAIR: I will just say, to take the secretary's point, if there are no officers here it is going to make it difficult. The only other reason I would prefer to stick to outputs if we can is because of some of our minor party crossbench colleagues.

Senator WATT: What is going to be your interpretation of what is in bounds and what is out of bounds?

CHAIR: I will firstly be guided by the secretary as to whether they have the officers here. The other thing is it is a general courtesy to your crossbench colleagues who are stretching themselves over a number of committees.

Senator WATT: I understand.

CHAIR: They are basing their agendas for the day around expecting at a certain time to be dealing with certain issues.

Senator WATT: So what is appropriate to ask now?

CHAIR: I suppose we will be guided by the secretary as to whether they have the officers, for a start.

Senator SINGH: I want to ask about something that was reported by News Corp on 12 February. They reported that the health minister had called GSK to request that they reinstate supply of the Bexsero meningococcal vaccine into Australia. The report said that the minister only acted after inquiries by a journalist. I want to know if that is your understanding.

Mr Bowles: That is a question best asked of the minister.

Senator WATT: Senator Nash, are you able to help us there?

Senator Nash: I am not, sorry, not being the minister responsible. I can take it on notice for you.

Senator SINGH: So you have News Corp reporting that Australians would regain access to this vaccine after it reported and made inquiries because of a personal call by the minister demanding that the vaccine's manufacturer boost the national supply. If that avenue were available, why was that not acted upon sooner? Why did it take a journalist to prompt action by government to ensure supply of this vaccine? I do not want you to answer with the same thing.

Senator Nash: You do not want me to answer it? I am happy to answer it. I am not going to go off the basis of media reporting. I have indicated that I will take it on notice, but I am not going to go off the basis of reporting in a media story that that is in fact the case. I have indicated that I will take it on notice and come back to you.

Senator SINGH: Why didn't the government act sooner?

Senator Nash: I have indicated that I will take it on notice.

Senator SINGH: Isn't it only because they were worried about a media story?

Senator Nash: Senator, you are making assumptions from media reporting in a newspaper. I have indicated that I will take the issue on notice for you.

Senator SINGH: What undertaking did GSK give the government after the minister's call? Did they guarantee supply?

Senator Nash: I am not sure if you are not hearing clearly. I am not the minister responsible. This is not an issue I am aware of, and I have indicated that I will take it on notice for you.

Senator SIEWERT: It is a big issue.

Senator Nash: So to continue asking me questions when I have indicated—

Senator SINGH: Well, I want to know if the supply is now guaranteed. Can you answer that question? Is supply of Bexsero now guaranteed here in Australia?

Mr Bowles: We will take that on notice.

Senator DASTYARI: How do you not know?

Mr Bowles: You are actually referring to a media release. We do not run policy by media release.

Senator SINGH: No. Now I am just asking you: is supply of Bexsero guaranteed in Australia?

Mr Bowles: It will be in relation to an area that will come up under outcome—probably—4. We can probably talk a little bit more about it there. I do not have the knowledge of every single thing that happens.

CHAIR: And, if necessary, I do not know whether it would be helpful to provide any articles that you are basing questions on just to assist witnesses with answers. Senator Singh, just a couple more from you, and then I want to move to Senator Xenophon and Senator Di Natale.

Senator SINGH: Has the department issued updated advice to parents on the ongoing shortages of Bexsero?

Mr Bowles: Again, I think it would be—

Senator SINGH: There is an official coming forward.

Mr Bowles: Again, it is outcome—

Senator Nash: Chair, I was just going to say that—and I really am just trying to assist the committee—what happens historically is: we have the list that we are working to and we know the specific items that are coming along. We tend to end up doing things two or three

times if we do them now and again later. Clearly, the officials that have the expertise in these areas have planned their day around when it is listed.

Senator WATT: I have something that is undoubtedly—

Senator Nash: No, no—and that is absolutely fine. But when the secretary says that it is better suited to later, if we could just accept that it is better suited to later then I think it might help the process of the day.

CHAIR: So we will move to that in outcome 4.

Senator SINGH: Does that mean that there might be some answers later then because you kind of have it on notice now for the next how many hours?

Mr Bowles: We will see how we go, Senator. As I said, we try and gear ourselves around the outcomes quite deliberately so that everyone can have a go.

CHAIR: I am all for seeing whether there is a possibility of getting answers in cross portfolio, but we do have to take on board the advice of the secretary as to whether we have the relevant offices.

Senator XENOPHON: Just very quickly: I think this is in outcome 1 because it relates to a general corporate matter. It relates to the whole issue of the tobacco plain packaging case under investor-state dispute resolution clauses in Hong Kong that Philip Morris brought, dragging the Commonwealth to that case. I am trying to establish what the legal costs were. I am told that it is a cabinet-in-confidence deliberation. Is that the position of the department?

Mr Bowles: Again, it is an outcome 2 issue. But, in the broad, as we went through at last Senate estimates—

Senator XENOPHON: Respectfully, it is a broader issue. I am not asking about the actual policy; I am just trying to understand—

Mr Bowles: And I am trying to answer you. I said, in the board, we went through this last estimates. We are keeping this in commercial-in-confidence around how we actually deal with the costs of this. As soon as we have settled this issue, we will make that quite obvious and quite public.

Senator XENOPHON: Leaving aside the argument and the High Court decision in *Commonwealth v Northern Land Council*—the 1993 High Court decision about what cabinet-in-confidence actually means—I just want to get to the actual amount of money that the Commonwealth expended in what I believe was a very worthy case but perhaps was unnecessary because of the actions of Phillip Morris. My criticism is not of the Commonwealth; it is of Philip Morris. You understand where I am coming from?

Mr Bowles: I totally understand where you are coming from and I do not want to prejudice our ability in this claim against Philip Morris around that particular case.

Senator XENOPHON: Mr Bowles, how is the Commonwealth's position prejudiced by just saying, 'These are the costs that we've had to play'?

Mr Bowles: Because we are asking them to foot the bill. We do not want to put that into the public domain when we are trying to have a commercial negotiation.

Senator XENOPHON: Having been a lawyer for around 30-something years and having dealt in cost disputes, if you put in a claim for costs presumably you cannot claim more than

your actual costs were, even on a solicitor-client basis. How on earth would saying, 'This is what we incurred, and we're going to try and get as much of that back from Philip Morris'—what is the problem?

Mr Bowles: Again, the advice we have given in the past is that we do not want to put that into the public domain while we are in discussions around this.

Senator XENOPHON: So you acknowledge that this is not cabinet in confidence, don't you?

Mr Bowles: I cannot remember what I said. I think I said commercial in confidence. I do not think I ever said cabinet in confidence.

Senator XENOPHON: No, you said 'declaration of cabinet' or 'a committee of cabinet'.

Mr Bowles: Yes, that is correct.

Senator XENOPHON: So it is cabinet in confidence.

Mr Bowles: Again, it really does relate to an Outcome 2 issue. We tried to give you the broad answers.

Senator XENOPHON: How close is the Commonwealth to resolving this? Is there a process? Does it have to go back to this arbitration process in order for it to be determined? Are you in the middle of negotiations? Is it imminent?

Mr Bowles: We will see if we can give you a quick answer now.

Dr Southern: Back in September both parties filed submissions on costs. We are expecting a decision in the first half of 2017, but no date has been set by the arbitration body.

Senator XENOPHON: Will there be a public announcement made or will I have to—

Mr Bowles: No, I gave a commitment at last estimates that as soon as we have actually got a resolution I will give you the cost.

Senator XENOPHON: But even if there is finally a resolution and Phillip Morris pays X dollars and the actual amount incurred was Y dollars—because normally in these things you do not get all your costs back, there is a solicitor-client and a party-party cost component—would it not be reasonable for taxpayers to find out how much they were out of pocket because of this egregious action brought by Philip Morris. Why can't we find that out?

Mr Bowles: Again, at that point in time I believe we will be in a position to do that. I totally accept where you are coming from on this, absolutely, because I think it is a pretty ordinary set of circumstances that they put us through, so I am very happy to make a lot of that public. I just do not want to prejudice our issues at the moment.

Senator XENOPHON: This is keeping me awake at night. It is like Christmas, I want to know what the amount is.

Mr Bowles: I understand that.

Senator DI NATALE: My question is for you, Professor Murphy. As the government's health advisor, have you been following the debate on the sugar-sweetened beverages?

Prof. Murphy: Peripherally, yes.

Senator DI NATALE: And the proposals to implement a tax on soft drinks?

Prof. Murphy: I have heard of these proposals, yes.

Senator DI NATALE: Do you have a view of the evidence that such a levy on sugar-sweetened beverages to reduce consumption would have an impact—

Mr Bowles: It is not appropriate to ask questions of government policy, and that is whether governments make those decisions.

Senator DI NATALE: This is government policy.

Mr Bowles: Whether this is government policy not—that is not what I said. It is very interesting when you take one word and take it out of context. It is not fair to ask the Chief Medical Officer things that are not government policy and that are speculated around in a whole range of different ways with multiple people having multiple views on the issue.

Senator DI NATALE: This is an empirical question that relates to very directly to Professor Murphy's role. I am asking him, not about a government policy, but about science. I know government policy and science are mutually independent on most occasions, but I am asking him an empirical scientific question. That is: has Professor Murphy looked at the evidence of sugar-sweetened beverages and does he have a view of the effectiveness of such a proposal? It is not government policy. Unless there is something you want to announce to this committee, it has nothing to do with government policy.

Mr Bowles: I think it is unfair to put an official in the middle of what is a sensitive political issue—

Senator DI NATALE: It is not a sensitive political issue.

Mr Bowles: I am afraid there are different views on this. I can say the department has not done work on this.

Senator DI NATALE: So I cannot ask the Chief Health Officer an empirical question about health intervention?

Mr Bowles: You can. I am making the point that you are putting an official in a very difficult position in a policy that is not anything to do with—

Senator DI NATALE: I am asking him a scientific question. Has he looked at the scientific literature? That is all I have asked. I am not asking him anything that—

Mr Bowles: I do not agree, but anyhow.

CHAIR: So your question is, 'Has he looked at literature?'

Senator DI NATALE: Have you seen any of the literature around sugar-sweetened beverages, Professor Murphy?

Prof. Murphy: Yes, I have.

Senator DI NATALE: And can I ask you, having seen the literature, what your view is of the effectiveness of a tax on sugar-sweetened beverages?

Prof. Murphy: I think it is too early to be conclusive. I think there is some evidence in some countries that it may have had an impact. At this stage it is only early evidence in some years and the benefits are theoretical. There is some early evidence of benefit, but I would just say that it is too early to draw any conclusions from the evidence.

Senator DI NATALE: There is some evidence of early benefit. What sort of benefit?

Prof. Murphy: There is some evidence that manufacturers may have changed formulations. In other situations there is no outcome evidence yet to prove the benefit. It is

only a small number of countries that have gone down this path, so my conclusion is that it is too early to say anything conclusive about it.

Senator DI NATALE: This is a general question: on issues like this, do you have a role in providing advice to government?

Prof. Murphy: Generally, across the department, on clinical issues I have a role for providing advice, yes. And if the minister requests advice on clinical issues, yes, of course, I provide advice.

Senator DI NATALE: This is perhaps less a clinical issue and more a public health issue. As a prevention strategy, is this an area where your advice might normally be sought?

Prof. Murphy: It might be. It has not been to date. I have only been in the role for a few months, but I have not been specifically asked to provide advice on this topic yet.

Senator DI NATALE: That is all.

Senator WATT: I think there is going to be no disagreement that this is a cross-portfolio issue: jobs. Mr Bowles, the department recently outlined that it would be asking for a number of voluntary redundancies within the department. What number are you looking for?

Mr Bowles: Firstly, yes, it is cross-portfolio, so I am very pleased to answer this one. We are looking to meet our budget targets for the 2017-18 year. I do not have a specific number of voluntary redundancies in that context, but we are looking at a whole range of issues like natural attrition and other things that happen when people get promoted and the like. One of the interesting things that we have seen in the department in recent times is that our attrition rate, people leaving the department, has dropped quite dramatically—because they all love coming to work in Health these days! It has actually dropped from 12.4 to 7.6. We have a range of programs that cease on a regular basis, and we have to match that to the dollars we spend and the staff we use. We are looking at is to get down to what we would call our affordable staffing level for the 2017-18 year, and one of the mechanisms we will use is voluntary redundancies.

Senator WATT: Did you say that this is partly prompted by your budget targets?

Mr Bowles: Every year we have our normal departmental budget. We have a whole range of staffing issues that we have to deal with. Programs stop; some start up. So we will see swings and roundabouts. We will probably go down some and increase some and do all that sort of thing.

Senator WATT: What is the percentage increase or decrease that has been budgeted for your overall departmental budget heading into 2017-18?

Mr Bowles: I could not tell you the percentage, but it does decrease from 2016-17 to 2017-18.

Senator WATT: Do you know by how much?

Mr Bowles: Approximately \$47 million, I think.

Senator WATT: The department's budget overall is to decrease?

Mr Bowles: The departmental budget, not our administered budget. It is not in the context of the \$90 billion. How we run the department is that a range of programs has ceased, we have the efficiency dividend and a range of other things that we deal with every year—and

have done for the last I do not know how many years; for a long time—and part and parcel of that is that we have to meet those targets.

Senator WATT: I am looking at a media report from 22 February 2017. I do not think I have copies of this with me and I do not know quite what publication it is in. I will try to find out. The journalist is Doug Dingwall.

Mr Bowles: *The Canberra Times*. I have seen that one.

Senator WATT: Okay: 'Health Department to cut 250 public service jobs through voluntary redundancy'. But you have told us that there is no number.

Mr Bowles: Not necessarily no number on voluntary redundancies. The figure will be anywhere between the 250 and potentially even a little bit higher, but we are not totally convinced what that number is yet. It will depend on what our natural attrition rates are and what some of the other factors are. But there will be a number of voluntary redundancies within that total number. We will have a whole range of non-ongoing contractors who will finish over time. We will have natural attrition. As I said, that is reducing, but we have a whole range of those issues that will happen between now and 30 June.

Senator WATT: So it could be a bit higher than the 250?

Mr Bowles: It could be marginally higher in total. It will not be through voluntary redundancies though. My assessment around voluntary redundancies is that it will be less than 200 and may be around 150, but we do not know yet and I do not want to be quite as definitive as putting a number on it at this point, because if we see attrition rates change, if we see some of the non-ongoings finish at different points in time, we may be able to reduce that, but it will be dependent. It is also dependent on a whole range of things that we are working on around how we actually change the way we do things as well.

Senator WATT: So it could be roughly 150 voluntary redundancies plus further people finishing up as a result of attrition or contracts coming to an end.

Mr Bowles: That is correct.

Senator WATT: And you do not really have a sense of the numbers there.

Mr Bowles: As I said, the 250 is not that far from it—

Senator WATT: In an overall sense.

Mr Bowles: but it could be little bit higher. Again, it will play out over the next couple of months.

Senator WATT: Are there particular areas that you are focusing on for those voluntary redundancies?

Mr Bowles: Not specifically, but we do have a couple of areas where we are doing some work at the moment and one of those is around our compliance functions. We are introducing a whole lot of data analytics technologies and that will see different ways of actually looking at compliance in the future.

Senator WATT: What sort of compliance?

Mr Bowles: It is things like when we look at the MBS and the PBS and the compliance with that. The world of compliance is moving from, effectively, people to technology over time. So, part of it will be how we actually restructure that area. Some of the other broad areas

in the department will be around how many people we have doing administration around some programs.

Senator WATT: You have effectively said that the rationale behind this, or the trigger for this, is to meet your budget targets.

Mr Bowles: Yes, it has ever been thus.

Senator WATT: Do you have a view yet on what APS level it is likely these voluntary redundancies will be recurring in?

Mr Bowles: It will be across the spectrum, I would suggest.

Senator WATT: Geographically are there any particular areas that you think are more likely to have redundancies than others?

Mr Bowles: If you look at the make-up of our staff, probably 25 per cent is in the states and territories and 75 per cent is in Canberra. I do not really envisage that it will be much different to that. But, again, I will not know until we actually go through the process.

Senator WATT: Thanks for that.

Senator O'NEILL: With regard to the suicide prevention trial sites and the PHNs as well—

Mr Bowles: That will be outcome 2.

Senator O'NEILL: I have just a few questions to see if we can get through some answers now. It would be helpful.

Mr Bowles: If we could stick to the program it would be much easier for the people I have got trying to answer. Otherwise I am trying to give you half an answer and it will not be any good. We have a program and I try to deal with it as best I can. I am sorry, Senator. I cannot have everything in my head, I am sorry.

CHAIR: Are you asking any questions in overview?

Senator O'NEILL: I have questions for outcome 2.

Mr Bowles: PHNs and suicide prevention will be in that outcome.

[10:21]

CHAIR: We are dealing with program 4.1, medical benefits.

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

Mr Bowles: Are you referring to the earlier measure around that? That is still obviously government policy until it is not. It is a question probably best asked of government, but in the strictest context that we are dealing with here it is still a policy of the government until there are alternatives put in place.

Senator WATT: So that is still a government policy. Can you give us an update on the implementation of the government's election deal with the Diagnostic Imaging Association?

Mr Bowles: Again, we are working with the minister around options around diagnostic imaging and pathology.

Senator WATT: So that is still underway?

Mr Bowles: Yes.

Senator WATT: I understand that the government's election deal with the association committed to an independent evaluation of the commercial environment for diagnostic practices. Who is doing that evaluation?

Mr Bowles: It was conducted by Deloitte.

Senator WATT: You used the past tense. The evaluation has been finished?

Mr Bowles: I will ask Mr Stuart to say a bit more about it.

Mr Stuart: That work is still ongoing. It is not finalised yet, but it has been going along reasonably well, and we are looking forward to seeing the final of that quite soon.

Senator WATT: What were Deloitte paid for their work?

Mr Bowles: We can take that on notice.

Senator WATT: That would be great. So Deloitte's work is completed, but the evaluation in a broader sense is still ongoing?

Mr Stuart: The Deloitte work is not yet finalised, and we have not fully paid for it yet. We have given progress payment. There is still payment outstanding.

Senator WATT: Have you received an interim report from Deloitte yet?

Ms Jolly: That work is being guided by a steering committee, which includes the government, the Diagnostic Imaging Association and others. We have been working with Deloitte on that. So, there is not an interim report as such. There has been an ongoing steering process throughout that report. But, as Mr Stuart indicated, it is close to finalisation.

Senator WATT: So, there is no interim report. Is there anything before we get to that stage—proposals for consideration?

Ms Jolly: There is just the final of the report.

Senator SINGH: The government has not received anything?

Ms Jolly: No, not at this stage.

Senator WATT: My understanding is that the deal that was done at the time of the election was that the evaluation would be done by 1 January this year. Is there a reason it has not been completed?

Mr Bowles: Again, it is a complex space. We are dealing with this as expeditiously as we possibly can. It has not been completed at this stage.

Senator WATT: I suppose not completing the evaluation and not reaching decisions would enable the government to make savings and delay putting any money back into diagnostic imaging, wouldn't it?

Mr Bowles: No. I do not understand. This is an issue that would go before the parliament anyhow. It would be a disallowable instrument, so it stays exactly the same. Nothing has been removed, so there is no issue there.

Senator SINGH: Why has there been a delay, then? What is with the delay?

Mr Bowles: We are working with government. We are working with the pathology and diagnostic sector around these issues.

Senator SINGH: But it has been three months.

Mr Bowles: Yes, it has, and it is a very complex set of issues.

Senator SINGH: That is quite a significant amount of time.

Mr Bowles: It is. It is a very complex set of issues that we need to deal with appropriately, and we will.

Senator WATT: The deal that was struck at the election says:

... there may be opportunities to realise further efficiencies worth as much as \$50 million per year by better targeting taxpayer investment.

No-one so far has been able to tell us what that means. Are you able to tell us?

Mr Bowles: In the broad, it is the work undertaken by the Medical Benefits Schedule review team, which is headed by Professor Bruce Robinson. All areas of the MBS, as we have talked about before in this committee, are being reviewed, all 5,700 items. Part of that is pathology and diagnostic imaging work. It is envisaged that there will be some issues worked through on pathology and diagnostic imaging by that committee.

Senator SINGH: What kind of issues? Budgetary saving issues?

Mr Bowles: No. Good clinical-outcome issues. As we talked about on the MBS review process before, it is about appropriateness. There will be some issues that will come off the MBS and there will be some issues that will go on. There will be some issues where we will actually look to revise how they are structured within the MBS itself. That is the job of the MBS review. It is conducted by clinicians; it is not conducted by me, per se, or the minister or the government. It is on the advice of a group of clinicians headed by Professor Bruce Robinson.

Senator SINGH: So, none of those issues will result in cuts to diagnostic imaging? Is that what you are confirming, Secretary?

Mr Bowles: That is not what I am saying. There will be a whole range of issues for which we will look at how they are currently structured, and that could mean some things change and reduce and some things increase. Some things will change overall.

Senator SINGH: Will there be cuts to diagnostic imaging out of this review process?

Mr Bowles: I cannot answer what the outcome will be of something that has not happened.

Senator SINGH: Well, it is something that is three months overdue—

Mr Bowles: No, we are talking about multiple issues.

Senator SINGH: and that you have been working closely with the steering committee on.

Mr Bowles: We are talking about multiple issues here. We are talking about the diagnostic imaging bulk-billing incentives, which was a policy position the government adopted. We have said that through the election; there was an election commitment. We have been working with the sector, and the Deloitte report is part of that process. When we actually get to a final point, we will be able to make that point.

Senator SINGH: I understand, but you did just say that there will be some things that will be reduced.

Mr Bowles: Again, in the context of the MBS review process, the natural consequence, if you have a look at some of the other things that have happened over time, is that the appropriateness of certain issues means that you do not do them anymore in the context of the

MBS. In your language, that is reduced. There are other things that are increased in the context of the MBS. You are sort of confusing the two issues. One is an MBS issue, which is done by Professor Bruce Robinson, and the other is the Deloitte issue and trying to structure how we look at the issue of diagnostic and pathology, because they are both in similar states.

Proceedings suspended from 10:30 to 10:45

CHAIR: We will recommence. Senator Griff, you have questions on outcome 4.1.

Senator GRIFF: I have a few questions regarding the MBS Review Taskforce, which I understand has been operational for a little over 18 months. How many items have actually been reviewed at this point?

Mr Stuart: We have 17 clinical committees established which are working through the 5,700 normal items and so far they have looked at or are in the process of looking at 57 per cent of those 5,700 items.

Ms Jolly: The items that came through in the first round about the removal of obsolete items are the main ones that have been completed through budget process at this point.

Senator GRIFF: What sorts of numbers are we looking at out of the 5,700?

Ms Jolly: As Mr Stuart indicated, about 57 per cent of those items are being looked at currently. In terms of items for which there has been a change that is now on the MBS schedule, there were—

Mr Simpson: There were 23 items changed.

Senator GRIFF: Were they items that were deleted or added?

Ms Jolly: They were part of a package of what was called obsolete items—items which the committee indicated were no longer clinically valid or necessary and so were removed or significantly changed.

Senator GRIFF: You said there are 17 clinical committees?

Ms Jolly: Yes.

Senator GRIFF: The website says it is 34.

Mr Stuart: Yes. We are looking at 17 that have been established and about another 17 that we expect will be formed in the future. They are up to 34.

Senator GRIFF: Do you consider a rate of progress of 23 changes to be what you expected?

Ms Jolly: There have been quite a lot of considerations. As I indicated, 57 per cent of items are being looked at. Regarding the process those items go through, there is a clinical committee formed. Those clinicians make recommendations.

Senator GRIFF: And then there are working groups.

Ms Jolly: Yes. Those recommendations then go to public consultation and those things are considered and then taken through to the task force. Consideration of the items is a very thorough process. Post that process you have obviously got government processes that surround that as well.

Senator GRIFF: When would you expect the review to be completed? What is your estimation?

Ms Jolly: We are continuing to work with the chair of the committee in terms of the pace of the new set of committees to be established, so I do not have a date at this point.

Mr Bowles: As indicated, 57 per cent are looked at at the moment. We will get our way through 100 per cent. This is an issue that we will continue to monitor, maybe not in the same form as it currently is. The whole issue of appropriateness of the MBS is something we will always keep an eye on. The process will change over time. We do not have a definitive end date for when we get to 100 per cent of the 5,700 items.

Senator GRIFF: How many of the working group recommendations are overturned at a clinical committee level?

Ms Jolly: I do not have that information, Senator. It is an independent committee. We work with those committees but we do not track that sort of discussion. As the clinical committees put out their consultation documents those documents are public and the task force will make their recommendations after they consider the public comment, in consultation with documents that flow back from that.

Mr Bowles: I think one of the really critical issues here is the nature of how this is reviewed through clinical input. We have been very clear that we do not want that influenced until we get that out in a public document, if you like, and you can have more of a public discussion around those sorts of issues. The whole nature of this structure is around how you have clinical input into the appropriateness of the MBS over the longer term.

Senator GRIFF: Just on that, given that clinicians on the working group and the committees are providing recommendations and that their names are made public on the website in cases where recommendations are rejected, doesn't that have the potential to create issues with, effectively, some of them feeling somewhat answerable to their colleagues? Is there any process that you have gone through to seek feedback from clinicians on the process and any negative impact or feeling that they may not want to make a recommendation because there might be an issue with their colleagues because it has been notified that they are part of the decision to reject?

Ms Jolly: On the selection of members to committees, I think the role that they are playing on those committees is part of that selection process. That is part of the decision to be part of a review like this. Whenever you are reviewing a range of clinical items, you will inevitably have discussions with your colleagues about decisions of clinical matters. I think that would be known to those who are there. Has the department had any formal checking in with members about those matters? No, we have not. That would be a matter for the chair of the committee as part of his role as an independent chair to keep an eye on those things. Certainly, if you are a clinician putting your hand up to be part of the MBS review, then some of those issues would be expected.

Mr Stuart: We have 450 leading clinicians working on these committees at the moment. The government has set up the task force, but the task force is the government's creation. The clinical committees that sit under the task force and the working groups that those clinical committees might ask to help them with their work are things the task force has set up. The minister and the government looked at the task force to basically mull over what comes to them and to form a view and to make recommendations to the government in the end. There is

a whole process of forming views, providing recommendations, sifting evidence and then providing advice to the government.

Senator GRIFF: What does running the task force actually cost? What is the cost of that operation?

Ms Jolly: There was an original allocation of \$34 million over a number of years and that funds both the MBS review and also the medical specialist advisory committee work. Both committees have engagement with the MBS and items that are being considered within the MBS structure. That amount of funds covers both of those activities.

Senator GRIFF: Given that hospital procedures can only be reimbursed by private health insurers if they are linked to a rebate item for the associated in-hospital care, is the department ensuring that this link is retained in cases where the MBS item numbers are changed or removed as part of this review?

Ms Jolly: We would expect that to be part of the consultation item and a consultation process, and also as part of the normal process by which MBS items are changed. But, yes, we would expect those considerations to be part of that.

Senator GRIFF: Could I have a bit of clarification? How many items are on the MBS altogether?

Ms Jolly: We talk about 5,700. I would have to take on notice the number today, just to ensure we have the exact number, but it is certainly in the order of 5,700.

Senator GRIFF: Thank you.

Senator WATT: Can we go back to where we were on diagnostic imaging? In response to a written question after the last estimates round, you advised that the Abbott-Turnbull government has granted four Medicare licenses since its election in 2013, and we discussed two of those at the last estimates. They were election commitments to marginal Victorian seats. Where were the other two?

Mr Bowles: For what in particular?

Senator WATT: Sorry, the four Medicare MRI licences.

Mr Stuart: We will just find if we have that information, so bear with us.

Mr Quinane: The other two were at Mount Gambier hospital and Epworth hospital in Richmond.

Senator WATT: Were all four full licences or were some of them partial?

Mr Quinane: Three of them previously did not have a licence, and they are full licences. One of them went from a partial to a full.

Senator WATT: Which one?

Mr Quinane: I believe that was Frankston. It was either Frankston or Maroondah. I will check that for you right now, just bear with me. It was Frankston that went from a partial to a full.

Senator WATT: Can you give us a list of new Medicare MRI licences granted by year back to about 2007?

Ms Jolly: We can take that on notice.

Senator WATT: You do not have that?

Ms Jolly: No, we do not have detail.

Senator WATT: Would you try to get that back to us today, if possible, even if it is a little bit later on?

Ms Jolly: We can see what we can do.

Senator WATT: Thank you. Just to be clear, I am not talking about licences implemented, I am talking about those that have been granted or decided.

Mr Bowles: Since when, Senator?

Senator WATT: Since about 2007. Can I also ask a couple of questions specifically about Darwin and the PET scanner issue there. I think in the last estimates my colleague Senator Polley asked about the PET scanner and cyclotron that had been promised to Darwin. Mr Bowles, I think that you said that that was a matter for infrastructure department. But health must have some role in that decision, mustn't it?

Mr Bowles: It was an election commitment.

Mr Quinane: The funding is coming through the infrastructure department, but our colleagues at outcome 7 today will be able to provide you with an update on that.

Senator WATT: You do not know the answer yourself?

Mr Quinane: No, I do not, Senator.

Senator WATT: We will return to that. Can I ask some other questions, still under this outcome relating to the MBS review, about skin cancer items. As a Queensland senator, with an office to be on the Gold Coast very soon, that is a very important issue for us. I am sure you can tell that I spend a lot of time in the sun, usually between the hours of 11 pm and 12 midnight. This is something that I have done quite a bit of media about on the Gold Coast and there is a lot of concern. The government made significant changes to the MBS skin items in November, and specifically the changes impact how certain MBS items for skin lesions, malignant and non-malignant, are covered under private health insurance. How have they been received and has the department had representations on this issue highlighting the problems with these changes?

Senator POLLEY: Just while the officers are coming to the table, I do not see any outcome 7.

Mr Stuart: We are just clarifying that, Senator.

Mr Bowles: I think it will be outcome 1 but we will clarify that.

Ms Jolly: Senator, as you have indicated there was a change to a range of skin service items. There was a consolidation of 57 items and a new schedule put in place. There have been conversations with a range of people who have come forward to the department and asked questions about the relationship to private health. I do not have those particular details with me, but I am aware of some of those discussions.

Senator WATT: You are aware of some of those discussions. Who has provided representations on those issues?

Ms Jolly: I do not have that detail with me but I am happy to take that on notice.

Senator WATT: Thank you. Were the changes to the private health insurance banding run past peak clinicians who were involved in the initial MBS review of the items?

Ms Jolly: That would not normally be the case but, again, I will take that on notice for the process that happened in that situation. Normally the clinicians that are involved in the original review would not necessarily be involved in the full implementation of the item as it works its way through.

Senator WATT: Is anyone else at the table aware of the answer to that?

Ms Jolly: We can take that on notice and get you that information.

Senator WATT: Just to be clear, what I am looking to find out is whether the MBS review working group was consulted on the banding changes as part of the review.

Ms Jolly: Yes, I understand that.

Senator WATT: And while we are clarifying, I must just go back to that point about MRIs and the question on notice about the number of licenses. I am asking for that detail to be provided on a year-by-year basis, for each year.

Mr Bowles: Yes, from 2007.

Senator WATT: Thank you. Back to the skin cancer issues: when did the department make the banding changes public?

Ms Jolly: I am not sure I have that data. I can include that in the response that we provide.

Senator WATT: Thanks. How much notice did medical practitioners, who may have had patients booked in for potential skin cancers to be removed, have to adapt?

Ms Jolly: The MSAC considered the outcomes in November 2015, so certainly the public statement from MSAC about the outcome of the skin services review was available at that time.

Senator WATT: Before November 17?

Ms Jolly: Sorry, was in November 2015. Then the changes came into place on 1 November 2016.

Senator WATT: So, introduced by November 2016?

Ms Jolly: Yes that is correct.

Senator WATT: And when you say it was available before that—how so?

Ms Jolly: The Medical Specialist Advisory Committee makes public, through a public summary document, its decisions, and so at that point the reasons, the rationale and the basis of the decision are made public. That is then taken into account in processes that government takes forward.

Senator WATT: The thing that you have taken on notice is when the advisory committee announced this?

Ms Jolly: The Medical Specialist Advisory Committee's role is in looking at the items themselves, the skin services items, from a clinical perspective. Your question goes to the banding issue that is related to that, which is a private health insurance arrangement. It runs through a separate committee. What I have agreed to take on notice is exactly the process by which that occurred and the dates on which the banding decisions occurred.

Senator WATT: Whatever date it is, is it true that medical practitioners really only had a few days' notice of this change before it took effect?

Ms Jolly: The decision was taken in the May budget and at that point it would have been in the public arena. So there was between May and November for the final government decision to be considered by—

Senator WATT: It would have been in the public arena or it was in the public arena?

Mr Stuart: It was in the public arena from the time that MSAC put its conclusions into the public arena as a recommendation to government. And so—

Senator WATT: I missed when that was.

Mr Bowles: November 2015.

Senator WATT: November 2015.

Mr Stuart: It would have been well known to the professional colleges from that time.

Senator WATT: Did the department or the advisory committee themselves advise practitioners that this was coming?

Ms Jolly: We would write to relevant stakeholders after the budget, as is normal practice, about changes that happen in the budget process. But you have asked about the banding decision, which is slightly separate to the budget decision and the MSAC process, so we will get you the details on that separately.

Senator WATT: Thank you. The concern that many of us have is that if a rebate is not paid for these skin cancers to be checked in the private system, that some patients may decide not to get those checks done for cost reasons. Have you been made aware that patients have pulled out of surgery or checks as a result of these changes?

Ms Jolly: I have not, no.

Senator WATT: So no colleges have raised that with you?

Ms Jolly: As I said, we have had representations regarding how the changes have flowed through to the banding scenario—that is what I have just agreed to take on notice. You also asked a specific question about whether individuals have made different clinical decisions, and I have certainly not had advice to that effect.

Senator WATT: I appreciate that you are taking on notice the details of the representations that have been made. Can you just give us a general sense of the types of issues that have been raised in those representations?

Ms Jolly: Generally when we make changes to MBS items we get representations from people wanting to understand how the items work and how they flow. That has been similar with the skin services review. The skin services review was slightly unusual in that it was quite a large set of changes to a series of items. Those changes were supported by and devised with the profession, but they did represent a significant change to the schedule. That is why there has been more questioning about how that now works than with most changes to the MBS.

Senator WATT: Mr Bowles, given what you said earlier today about the effect of price signals, would you agree that, in this instance, if people are potentially facing personal out-of-

pocket costs that would previously have been covered, that might deter them from getting their skin cancers checked?

Mr Bowles: I would not necessarily go down the same line with that. If this is a decision of the Medical Services Advisory Committee, MSAC, it would have been based on clinical issues. That then flows through to other processes. That is the normal way our system works with independent committees. They make decisions about clinical issues and I do not get involved in intervening in those decisions.

Senator WATT: In this instance price signals would not necessarily work?

Mr Bowles: I think you are twisting my words again.

Senator DASTYARI: He does it so well!

Senator WATT: I am just trying to hold you to what you said.

Mr Bowles: I agree with Senator Dastyari that you are doing very well at twisting my words.

Senator WATT: All I am doing is repeating back to you what you said.

Mr Bowles: No, you are not. I disagree with that analysis.

Mr Stuart: I think the core issue here is that the Medical Services Advisory Committee is the expert committee charged with figuring out what services are necessary and evidence based—and should therefore be funded. If they have made a recommendation about what should or should not be funded, that is the gold standard in Australia.

Senator WATT: In the representations that have been made, is there any suggestion that patients may have been told that they were covered to get these procedures done, got them done, and then found out that they were in fact not covered?

Ms Jolly: As I said, I will have to take that on notice.

Senator WATT: Have you been made aware that these changes, including the option of writing to insurance companies to seek coverage, are ineffective and that insurers are rejecting these claims?

Ms Jolly: Not specifically in that context, but, as I said, I will need to take on notice issues relating to those representations. I want to make sure I am accurately reflecting them.

Mr Bowles: If consumers are writing to insurers we would not necessarily know about that.

Senator WATT: Are you aware, through representations made to you, that insurers are now rejecting these claims?

Ms Jolly: As I said, I will take on notice issues relating to the representations. There is correspondence that comes to the department occasionally on those sorts of matters, but that is broadly across private health insurance. On this matter specifically, as I said, I would need to take on notice the details of the representations, but I am not aware of anything specifically on that matter.

Senator WATT: I know you have been very careful to say it is an independent decision of this advisory group, but, if this is not motivated by saving money, why would the department not just reverse the specific item changes that you have been told by medical practitioners are causing people real problems?

Ms Jolly: There are two separate lines of decision here. One is the decision from the Medical Services Advisory Committee about the skin services review and how those items should be structured. Then there is a separate set of decisions about how that flows through to private health insurance through the banding process. You have asked about that separate decision on the private health insurance banding process. That is the question I have agreed to take on notice.

Senator WATT: Thanks. I will hand over to someone else. I know Senator Dastyari has some questions he has to get to by midday as well.

CHAIR: Senator Di Natale, would you like to kick off?

Senator DI NATALE: I might begin with the MBS freeze. Has the department done any work to indicate what the costs of lifting the freeze will be over the forward estimates?

Mr Bowles: The department has provided advice to the minister on various options around the MBS freeze, as we would normally do.

Senator DI NATALE: What would the cost be of lifting the freeze over the forward estimates?

Mr Bowles: I would have to take the specifics on notice, but I think I have been on the record before of saying it is over \$3 billion. I could not give you the specifics—and that is for every single thing on the MBS freeze.

Senator DI NATALE: No problem.

Mr Bowles: We will take that on notice for the specifics.

Senator DI NATALE: Okay. If you could provide that specific figure, that would be helpful. In terms of consultation, what consultation have you done with specific stakeholders around the freeze itself since the new health minister took on the role?

Mr Bowles: I think the health minister has been quite open that he has been having conversations with the various groups. That is probably a question best asked of him—what he has done.

Senator DI NATALE: What have you—

Mr Bowles: What have I specifically done?

Senator DI NATALE: Yes.

Mr Bowles: I have had no formal—

Senator DI NATALE: What has the department—

Mr Bowles: Our job is to provide advice to the health minister, and we continue to do that. As far as what consultation the department has done specifically with the stakeholders: we are not necessarily in that space. Personally I have had conversations with the AMA, for instance, but not in any specific detail.

Senator DI NATALE: There were reports that the AMA and the Royal Australian College of General Practitioners have been in consultation on the freeze. Have you had consultations with them specifically about the MBS?

Mr Bowles: I have had a broad conversation with the AMA but not the RACGP. As I said, it is public knowledge that the minister has had a number of conversations with the AMA and the RACGP. In fact, the minister has been quite open about those consultations.

Senator DI NATALE: This might be a question for the minister. I understand that the Prime Minister has said that there is the prospect of reviewing the freeze subject to 'a very clear set of reforms that will help make the system stronger and better.' Could you shed some light on what the Prime Minister meant by that.

Senator Nash: The minister is obviously undertaking a whole range of consultations in his new role as health minister across the sector. I cannot comment directly on that, and it would be a question for him.

Senator DI NATALE: This was the Prime Minister who said this.

Senator Nash: Indeed. But it is a matter for the health minister and the Prime Minister to respond. I am happy to take that on notice for you, though.

Senator DI NATALE: Specifically he said that it would be subject to a very clear set of reforms. Obviously if they are very clear then they will be outlined. Could you provide on notice information as to what those reforms are, if you do not have that at hand.

Senator Nash: I can try and do that for you.

Senator DI NATALE: The other thing is—and I do not expect you to confirm this—given the recent comments from the Prime Minister and the new health minister and the stakeholders involved that we look to be moving towards an end to that freeze possibly in the budget, can you give a commitment that the savings will not be sought from within Health? I am asking you, Minister.

Senator Nash: It is a bit difficult I think to ask me the questions. I am very happy to take some of this on notice for you for the minister, but I certainly can only do that for you.

Senator DI NATALE: Perhaps I could ask you, Mr Bowles: as part of the work that you have done around the freeze and the modelling of that, are you looking to recoup the costs of that \$3 billion in other areas of Health?

Mr Bowles: That would be a decision for the minister and government in the context of the budget, if they were to decide on that as a course of action.

Senator DI NATALE: Have you done any work to model \$3 billion of savings in Health, specifically in relation to—

Mr Bowles: We always do work on modelling savings across the \$90 billion of the Health budget around a whole range of issues across the MBS, PBS and just about anything else in the budget.

Senator DI NATALE: Perhaps I will go to the MBS review now. Can you just give me an update on the status of the review. I am not sure that we have had detailed—

Mr Bowles: While you were out of the room we had a conversation about this. Ms Jolly can fill in a bit of detail for you. But in the broad, while she is getting her place, we are at about 57 per cent of the 5,700-odd items in the MBS—at least having a look at. So that is roughly where we are. Ms Jolly might be able to add some more.

Ms Jolly: There have been 17 clinical committees established, and there—

Senator DI NATALE: We had this information around the 17 committees. I do not want to waste the Senate committee's time; I will get that information. But we are 57 per cent of the way through all the MBS item numbers?

Ms Jolly: Yes.

Senator DI NATALE: When do you expect the review to conclude?

Ms Jolly: We do not have a date for that.

Mr Bowles: This was asked earlier on. But basically I said that we do not have a specific date to conclude it. We want to look at 100 per cent of the items, but my personal view at this point was that we will always continue to keep looking at this. I think the form of how we look at this into the future might be different.

Senator DI NATALE: Yes. Well, I would expect that it would be, given the way this has been done. Can I ask: the funding for this review is \$32 million. Is that right?

Mr Bowles: I think it was \$34 million.

Ms Jolly: I think we gave a figure of \$34 million over the two years.

Senator DI NATALE: When does that run out?

Mr Stuart: I just want to clarify: that was an amount of funding which included the MBS review and funding for the Medical Services Advisory Committee together, and we do not have a forward split as to how much is for each purpose. But we could, if you want us to take on notice what the split is—but it is the \$34 million for both together.

Senator DI NATALE: And you have not decided how you are going to spend the rest of it? How much of it has been spent so far?

Ms Jolly: Can we take that on notice, and we will give you the breakdown of what has been spent on the committee.

Mr Bowles: The two issues are run largely together. That is the issue. The whole MSAC process and the MBS review obviously link.

Senator DI NATALE: They are being run together. So, perhaps on notice: how much has been spent so far in each area and what does the prospective split into the future look like?

Ms Jolly: I am happy to do that.

Senator DI NATALE: What sort of consumer involvement has there been through this process? Just remind me. I know you have the various committees. What is the role for representation of consumer groups?

Ms Jolly: There is a consumer on every committee. There has also been—

Mr Stuart: And the task force.

Ms Jolly: And the task force. There has also been some separate conversations with consumers. Particularly when the task force was established we ran some workshops, and I think that work is ongoing.

Mr Simpson: We also have a consumer panel, where those consumers who are on each of the clinical committees are coming together to work together. There are about 27 consumers involved across the process.

Senator DI NATALE: I will move to the pathology rent deal. Can you just give me an update on the status of the rent deal between general practice and the pathologists.

Mr Bowles: It is still a matter of discussion with the minister, effectively. We covered a little bit of this territory before as well. The positions around the bulk-billing incentives are

still in place until we finalise any arrangements with either pathology or diagnostic imaging, which we talked a bit about before.

Senator DI NATALE: This has obviously been delayed significantly. There was a proposal put forward. Why has there been such a long delay?

Mr Bowles: It is a complex set of issues that we are dealing with the sector on.

Senator DI NATALE: I understand that during the election campaign the Prime Minister announced that he had struck a deal. We are now many months beyond the election campaign, with work leading up to the election. Do you have a planned time line for the changes?

Mr Bowles: No final date at this stage. It is a matter for the government to finalise. As I said, I answered this earlier on. This is a complex set of issues that we are dealing with the government on.

Senator DI NATALE: Apparently Donald Trump agrees with you, by the way. Apparently health care is very complex.

Mr Bowles: I did see that. I was pleased to hear it.

Senator DI NATALE: Who knew?

Mr Bowles: Yes, who knew?

Senator DI NATALE: Who are you consulting with on the changes? What parties are subject to the discussion around the changes?

Mr Stuart: We have been talking to a wide range of parties, dating from a roundtable that we had last year. That includes various representatives of pathology interests and general practice interests, and the AMA more broadly.

Senator DI NATALE: Has the Medicare campaign conducted by one of the major pathology companies during the election campaign played a role in the delay?

Mr Stuart: Which campaign?

Senator DI NATALE: The campaign run by one of the pathology companies that objected to the proposed changes during the election.

Mr Bowles: No, Senator.

Senator DI NATALE: At this stage you have no time line as to when this is going to be bedded down?

Ms Jolly: Senator, I am just going to point to a MYEFO decision that was taken which announces the change to the time frames to delay until 1 July 2017. That was to allow further consultation with stakeholders.

Senator DI NATALE: What is budgeted there?

Ms Jolly: That is a delay in the start date that was announced in MYEFO across both the pathology and diagnostic imaging bulk-billing changes. It is a single figure across both. It was \$210.7 million, which is the cost of the delayed start date.

Senator DI NATALE: So the MYEFO does not indicate that there will be any changes to the arrangement; it just delays them until the start of—

Ms Jolly: That is correct.

Mr Bowles: While we discuss with the appropriate people.

Senator DI NATALE: Please explain some of the complexity to me. I assume it is about negotiating down the rents.

Mr Bowles: Negotiations do take time.

Senator DI NATALE: Yes. But just explain to me why it is taking so long.

Mr Stuart: We canvassed some of this at the last hearings, Senator.

Senator DI NATALE: I know. They were a long time ago.

Mr Stuart: Yes, but the same complexity is still an overriding issue, and that is about differing views around what is an appropriate market comparator for rents in the pathology clinic space. That is an issue which has strong views attached to it on different sides of the debate.

Senator DI NATALE: But market rents are market rents, aren't they? I get that people might be attached to the rents they are receiving and other people might be vociferously opposed to the rents they are paying, but isn't the principle that you are just trying to land at where market rent is and strike a negotiation there? Complexity can sometimes occur because it is technically complex. It seems to me that there are clearly stakeholders on different sides of this debate. That is a different sort of complexity and it requires a decision—

Mr Bowles: No, all of those things are true. There is regulatory complexity in the current arrangements, there is significant complexity in how you would frame a future arrangement and then there are different views about what is an appropriate way to define a market for pathology collection centres.

Senator DI NATALE: Okay. I wonder if we are going to hear about how complex it is at the next estimates hearing or whether we might actually get a resolution to it, because I know there are a lot of people who would like to see a resolution.

CHAIR: That brings an end to outcome 4.1.

Mr Bowles: I would just like to clarify a point raised earlier around the PET scanner at Darwin. It is outcome 1.3.

CHAIR: Does anyone have questions on 4.2?

Senator DASTYARI: Would it be possible to jump to 4.4?

CHAIR: There are no questions on 4.2. You are on 4.4, are you, Senator Dastyari?

Senator DASTYARI: I know the committee cannot agree on much, but the view that if I ask my questions I will then leave normally brings the committee together!

Senator POLLEY: Yes, we agree!

Senator SIEWERT: I am due at another committee. I am just wondering how long you are going to be, because I have hearing questions.

Senator DASTYARI: Probably about 20 minutes. Fifteen minutes? Ten? Do you want more or less?

Senator SIEWERT: I am just trying to work it out, because if we were following the normal program I would ask my questions and then go next door.

[11:25]

CHAIR: We will do hearing, program 4.2.

Senator WATT: I think I will have a couple more on 4.1, but we can do it after.

CHAIR: The point is that we are trying to move through the program. If you have further questions, I would encourage you to put them on notice.

Senator WATT: Sure.

Senator SIEWERT: First off, I just want to follow up an answer to a question on notice that I got back. It is question SQ16-000418. It was about the level of hearing loss and what would happen if people disagreed with what the NDIA determined, and you said, 'Go and ask the NDIA.' I will ask the NDIA, but that raises the question of what happens if there is a difference between what level of hearing loss or hearing impairment you are working to and what they are working to. What happens in that case?

Ms Garrett: We are working closely with the NDIA to make sure that we understand what they set as the hearing loss thresholds so that we can make sure that our program continues to be able to provide services for those people that still need those services. So we are making sure that they are aligned.

Ms Jolly: We are working with the NDIA to ensure the scenario you have outlined does not happen and there is not a gap between the two programs.

Senator SIEWERT: So you would change yours if they determine it? There is some conjecture as to the level they are going to set it at.

Ms Jolly: Yes.

Senator SIEWERT: You would then change yours to meet theirs?

Ms Jolly: Ultimately, to change the program guidelines, we would need to have a decision of government, but at this stage we are working very closely with the NDIA to ensure, as Ms Garrett said, that we are very clear on how they are targeting their eligibility criteria and therefore to try to make sure we do not have that gap.

Senator SIEWERT: With all due respect—and I appreciate what you have just told me—that is not a clear answer. I do understand it is up to government. In terms of the recommendation, if NDIA changed it, would you then recommend—I understand the prerequisites you have just put around it—that you change yours?

Mr Stuart: I think the situation is more that there are a range of customers currently obtaining hearing services through the health department's program. When the NDIA determines the eligibility threshold for them, people will either transition to that program or remain with ours; there will not be a gap.

Senator SIEWERT: I understand the issue about remaining with yours, and in fact it came up during the inquiry, and I will try not to confuse the two things here—the inquiry into hearing services and NDIS. I understand about existing clients. I am also interested in new clients. Will that be the same for new clients?

Ms Jolly: It is a bit hard to answer that definitively, because the changes that Mr Stuart has outlined do not come fully into effect until 2019-20. So at this point we are working through the process with existing clients and with the eligibility guidelines and going through that process, but then, going forward from that date, you are asking questions about what that looks like for new clients going forward, and I am not sure we can answer that definitively.

Mr Stuart: The department's advice will be based on ensuring that there are no service gaps arising.

Senator SIEWERT: I have been assured about that through other things on the NDIS, not here. I have to say that there are huge question marks hanging over that. There are huge concerns in the community about what happens to midwives and people who need support and whether it is going to look very different. With all due respect, I understand where you are saying but it does not satisfy people out there who are worried about where a gap may develop for new clients. When is it likely that you will be resolving the issues around new clients so that there is a degree of certainty for people?

Ms Jolly: Our program guidelines have not changed. They will remain as they are. For new clients they will remain in the way that they are currently.

Senator SIEWERT: I am not trying to trick you or anything like that, but you have just said that there is a possibility that guidelines will change depending on the NDIA—

Ms Jolly: That is a 2019-20 question. I apologise if I have introduced confusion. We have several processes that are running. We have the current program which is continuing. There are no changes in that program. That program is rolling out. It is under legislation et cetera. We are working with the NDIA on their eligibility criteria. As Mr Stuart indicated, there will be a transition of those onto the program or they will remain on the current program. When that full transition is in place, which will be in 2019-20, then some of the questions that you are raising about the future state of the programs will be clearer. At this stage, the guidelines for new clients for our programs have not changed. They are the same.

Senator SIEWERT: I understand that. This is probably a question more broadly for the department, but surely you are not going to wait until 2020 to work out what you are doing with new clients?

Mr Bowles: I think everyone has made clear that, while the implementation of this is 2019-20, our intent is that there will be no service gap. They are eligible under the current arrangements. Once we work out what the cut-off period is for NDIA we will then have to adjust our program to deal with the NDIA. What we are saying is that we do not envisage there will be a gap, but it is premature to talk about what the changes might be because we do not really understand the implications of that yet.

Senator SIEWERT: I think we are going to keep going around in circles. I think it will become clearer once the NDIA set their level, and I will come back and ask these questions again. We cannot wait until 2020 for you to make up your mind about what is going on.

Mr Bowles: But people will still get into our program under the current rules because they have not changed.

Senator SIEWERT: Until 2020?

Mr Bowles: Up until that point, yes.

Senator SIEWERT: I understand that point. I am concerned about what happens beyond that. I want to go back to a question I asked earlier. There is some discussion around where unilateral hearing loss is going to sit and whether people with unilateral hearing loss are going to get supported through the NDIS. That is still under review. Where are you at with unilateral hearing loss?

Ms Garrett: I will have to take on notice to find out the current rules for the program.

Senator SIEWERT: It would be good if you could. Can you also look at whether you have had any discussions with the NDIA about that.

Ms Jolly: Okay.

Senator SIEWERT: Thank you. That is much appreciated. I want to go on to the review. Last year you were still looking at the inputs from the consultation that you did. Can you give us a quick update or summary on where that process is that. If it is a longer summary, you could table something.

Ms Garrett: I will give you a quick summary. At our last session we talked about the review of service items and fees and that it was being paused because stakeholders wanted to see the review of device supply at the same time. The review of device supply of assistive hearing technology is underway. We intend that they will come together and then a consultation paper will be released in April.

Senator SIEWERT: So the consultation on the devices is still underway?

Ms Garrett: That is right. The information gathering for informing that public consultation paper is still underway.

Senator SIEWERT: Is that information gathering with stakeholders?

Ms Garrett: Yes, with stakeholders. That is a broad range of stakeholders to ensure that the consultation paper that is released in April has as much consideration of the range of views as possible.

Senator SIEWERT: So the consultation paper is coming out in April; how long will it be out for?

Ms Garrett: It will be out for a reasonable period of time, to ensure that we can get as many views as possible.

Senator SIEWERT: A couple of months? Okay, thank you. I suspect some of my other questions may then be a little bit premature. As part of that process, will you be looking at the provision of rehabilitation services in the paper?

Ms Garrett: Yes, they will be included.

Senator SIEWERT: And going more broadly than just audiologists and audiometrists?

Ms Garrett: Yes.

Senator SIEWERT: When that goes out for consultation, will you be holding any roundtables or any other processes of bringing stakeholders to talk about that process?

Ms Garrett: It has not been planned, but it is possible that we will look at that. It will depend on the responses to that consultation.

Senator SIEWERT: I am sure you are aware of the campaign that the Deafness Forum is now running about making hearing health a national health priority. It is probably an issue for the department and the minister, but have you responded to their call yet, or are you intending to?

Mr Bowles: We have not as yet, and I think we would have to think about how we respond. How and if we respond.

Senator SIEWERT: I take it from that that that you are aware of their campaign, so at least that is some progress. So you do not know if you are going to be responding.

Mr Bowles: I would need to think about that.

Senator SIEWERT: Could you take in on notice?

Mr Bowles: I will take on notice about how I think about that.

Senator SIEWERT: I want to know whether you actually are taking it seriously, because it is a pretty serious campaign.

Mr Bowles: Every time we encounter these sorts of things we think before we actually respond. We just want to go through a bit of a process on our side.

Senator SIEWERT: I think we traversed my other questions earlier, but I have one last question about the review. I appreciate that the process was changed, but what is your end date for the finalisation of the review? I understand the consultation process will be going for at least a couple of months, by the sounds of it. What is now your end date for that process?

Ms Garrett: The end date will have to be this year, but there is no specific milestone planned. It will depend upon the consultation.

Senator SIEWERT: In terms of the hearing review that we are undertaking through the joint NDIS committee, have you been having a look at those submissions?

Ms Garrett: Yes.

Senator SIEWERT: Will you be in a position to comment on those positions to the committee?

Ms Jolly: I am not sure that we would provide comment on other submissions. There was a specific—

Senator SIEWERT: For the issues raised, I should say. Sorry, I beg your pardon. I was not clear. I meant the issues raised.

Ms Jolly: You are referring to the NDIS—

Senator SIEWERT: Yes.

Ms Garrett: The joint standing committee on the NDIS?

Senator SIEWERT: Yes.

Ms Garrett: Are you asking us to comment on those issues to this committee or to the joint standing committee?

Senator SIEWERT: To the joint standing committee. I do not want to traverse the issues that we are traversing here, because it is not appropriate. I am asking whether you will be providing—

Ms Garrett: The Department of Health has provided a submission to that committee, and we have not been asked to appear before that committee.

Senator SIEWERT: We will be following that one up. In terms of ongoing issues that have subsequently come up, as a number of them have, will you be looking at those to provide the committee with further advice?

Ms Garrett: Yes, we can look at those issues.

Senator SIEWERT: Thank you.

[11:40]

CHAIR: We are on hearing services, program 4.2, but I am trying to accommodate Senator Dastyari, who is very difficult to say no to. He has to depart at midday. If no-one else has questions on hearing services, with the indulgence of the committee, to accommodate Senator Dastyari, we will jump to program 4.4, and then we will come back to program 4.3 and progress as previously advised. So we will go now to program 4.4—private health insurance.

Senator DASTYARI: I will try to get through this fairly quickly, because I know there is quite a lot to get through today. Mr Bowles, some of what I am going to ask is specifically related to the Health portfolio. Some of it may have a little bit more to do with finance and other areas, so just pull me up and say where it correlates and where it does not. Before I get to the more specific questions, I want to get an understanding of how that interaction works. What figure are we looking at in the budget line item for what gets spent on private health insurance this financial year?

Mr Bowles: You are talking about the rebate figure, I assume?

Ms Jolly: You gave that figure earlier.

Mr Bowles: I gave that figure a little earlier. I just cannot remember. It is around \$6 billion.

Senator DASTYARI: Around \$6 billion?

Mr Bowles: Marginally over, I think.

Senator DASTYARI: It is a publicly available figure.

Mr Bowles: Yes.

Senator DASTYARI: So we spent \$6 billion on the rebate. That comes straight through the Department of Finance, or does it? How is it accounted?

Mr Bowles: The figures I gave to Senator Di Natale earlier today—

Senator DASTYARI: It is counted in health expenditure?

Mr Bowles: It is counted in that \$90 billion figure that I gave, of whole-of-government expenses. Some of these things are paid through Finance or Treasury, through different mechanisms—for example, public hospital funding goes out through different mechanisms. But in the overall context of the health budget, of the \$90 billion I referred to before, approximately \$6 billion is the health insurance rebate.

Senator DASTYARI: What I was not able to find in publicly available data—I am sure it exists somewhere, so you might want to take this on notice—is where that \$6 billion for the rebate ends up going in relation to the different health insurance providers. I am talking about Bupa, MBF and others. I looked and—

Mr Bowles: I doubt we will be able to give you a break-up in that way.

Senator DASTYARI: Why?

Mr Bowles: This is a rebate to individuals.

Senator DASTYARI: But for them to be able to apply for the rebate they would have to provide you—

Mr Bowles: It would be a big job, I would imagine, for us to do that. It is probably Human Services that would do the implementation of that. But I think that would be a difficult one. We could not do it. We can take on notice how you might do that but—

Senator DASTYARI: No. Can I get you to take on notice a separate question. The question—and it seems like you do not know the answer, which is completely fine—is whether or not that information is collected and aggregated. If it is already aggregated, it might be available somewhere. Are you able to take on notice—

Mr Bowles: We can take that on notice.

Senator DASTYARI: Can you take on notice how you would get that information? It may already be aggregated. My understanding is that, for me to apply, I would have to provide you and show you—

Mr Bowles: Through the tax system.

Senator DASTYARI: Through the tax system, but I have to demonstrate that I am in private health insurance, because it is a rebate.

Mr Bowles: In the broad, you will get something from your private insurance that says you are paying whatever. If you meet the criteria around salary and all that sort of stuff, you get your rebate through the tax system. That is effectively how it works. So it would be difficult for us, I think, to get the answer you want about each of those things—

Senator DASTYARI: They probably do not collect it.

Mr Bowles: Yes. We will take it on notice.

Senator DASTYARI: Okay. Explain to me also the process for someone to be an approved healthcare insurance provider. Not anyone can do that. I cannot just set up a health insurance company and be eligible for the rebate. It is done through your department, through DHS?

Mr Bowles: Through APRA—

Senator DASTYARI: Now that APRA has taken over?

Mr Bowles: The prudential regulator would set that. Effectively, they have to prove themselves to APRA before they can become an insurer.

Senator DASTYARI: That is since last year?

Mr Bowles: Before that it was through PHIAC. What does that stand for?

Ms Duffy: The Private Health Insurance Administration Council. Prior to the Australian Prudential Regulation Authority taking over the function, it was done by the Private Health Insurance Administration Council.

Senator DASTYARI: So you have no role in the determination. APRA look at it from an insurance perspective, not necessarily a health services provider perspective. I have dealt with APRA. They look more at whether or not they can pay out claims, liquidity and other matters. In terms of making a determination on whether actual services are being provided adequately, or the adequacy of cover, what is your involvement in that, or is there none?

Ms Duffy: The department works with APRA. Once APRA receives an application, the department's role is to have a look at the proposed policies to make sure that the policies are in line with the requirements under the act. The department then provides advice back to APRA.

Senator DASTYARI: You might want to take this on notice, or you might already have the number. How many approved entities are there?

Ms Duffy: How many private health insurers are operational right now?

Senator DASTYARI: Yes.

Ms Duffy: Thirty-six.

Senator DASTYARI: You may need to take this on notice, which would be completely understandable. Can you put that in perspective? How has it been in the last three years? Are there more, or are there fewer? Is there more competition, less competition?

Ms Duffy: It is pretty stable. In the last 12 months have been two additional insurers added to the list of insurers. If you want past years, I will have to take that on notice.

Senator DASTYARI: If I were going to try and get my head around what the market share would be among those 36, is that publicly available? Is there somewhere that that would be calculated that you are aware of?

Ms Duffy: Again, APRA collects information about market share, expenditure and revenue.

Senator DASTYARI: APRA is here tomorrow morning, so I will ask them. For someone to be able to get on the list, obviously APRA will look at the financial side of it and you will look at the health side of it. I am simplifying what I am sure is a much more complicated process. Is that correct?

Ms Duffy: Correct.

Ms Jolly: Correct. Our reference point is obviously the legislation.

Senator DASTYARI: If I had questions regarding the transparency issues relating to the health funds themselves, they would be matters for APRA?

Ms Duffy: It depends what you mean by 'transparency'. Do you mean policy transparency or financial transparency?

Senator DASTYARI: Both.

Ms Duffy: In terms of the policies that are made available to policyholders, the department looks at whether the policies contain all the relevant information and exclusions or non-exclusions. In terms of financial transparency, that is a matter for APRA.

Mr Stuart: This also involves the ACCC.

Senator DASTYARI: Of course.

Ms Duffy: And the ombudsman.

Senator DASTYARI: If we can get more specifically to the private health insurance premiums, they are going up on 1 April. Is that correct?

Ms Duffy: Yes.

Mr Stuart: That is normal practice. Yes.

Senator DASTYARI: And what amount are they going up this year?

Mr Bowles: The average was calculated as 4.84 per cent.

Ms Duffy: Yes, 4.84.

Senator DASTYARI: So that is 4.84 per cent on average. You must have a calculation. What does that mean in dollar terms for, say, an average single and an average family?

Ms Duffy: When the minister approved the premium round for this year, he was able to put out as part of the media release that on average for a single it is around a \$2 increase and on average for a family it is a \$4 increase per month.

Senator DASTYARI: So \$2 a week is what a year?

Ms Duffy: Per month.

Mr Bowles: So \$24.

Senator DASTYARI: Sorry—\$2 a week or \$2 a month?

Ms Jolly: Per week.

Mr Bowles: Sorry, per week.

Senator DASTYARI: For a single person you are saying \$2 a week, so annually that is—

Mr Bowles: \$100, roughly.

Senator DASTYARI: For a single person, \$100 a year, and for a family?

Mr Bowles: \$200.

Senator DASTYARI: In the media release, the minister also said that some premiums will go up by as little as three per cent, which still sounds like a fair bit, to be honest. But that is obviously the lowest. What is the highest?

Ms Duffy: Each of the averages for each of the insurers is on the department's website.

Senator DASTYARI: Okay, but that was not the question. The question was not: what are the averages? The question is: what is the highest?

Ms Jolly: We might need to take that on notice. What is put on the website is the average—

Mr Stuart: For each company.

Senator DASTYARI: But surely you know that. Surely that is just sitting there in your folder.

Ms Duffy: Do you mean the average for each insurer?

Senator DASTYARI: I am saying: not the highest average; what is the highest increase?

Ms Duffy: No; I do not have that information.

Mr Stuart: There are a great many policies across the 36 insurers.

Senator DASTYARI: But then why does the press release say the lowest?

Ms Duffy: That is an average weighted across the industry.

Senator DASTYARI: So the average weighted lowest is three.

Mr Bowles: Of the then 34 insurers that were on that.

Senator DASTYARI: If the average weighted lowest is three, what is the average weighted highest?

Ms Duffy: It is 8.53.

Senator DASTYARI: One is going up three, one is going up 8.53, everyone else falls in between and that is how you get the average. See? I did that all by myself.

Senator Nash: Well done, Senator!

Senator DASTYARI: Which one is the 8.53?

Ms Duffy: It is health.com.au.

Senator DASTYARI: So health.com.au is going up 8.53 and the lowest, which was three—who was that?

Ms Duffy: CBHS.

Senator DASTYARI: So 8.53 in dollar terms—if we kind of double that, you are then looking at double those amounts again?

Mr Bowles: You have also got to understand the number of policyholders they have within each of these areas. So, health.com.au would only have a small number of members, whereas some of the other big ones have very large numbers of members. That was your issue before about the market share of each of them.

Senator DASTYARI: And this stuff is obviously publicly available. Ms Duffy, can you take something on notice for me. Are you able to produce a table that gives us the averages for these 34 or 36 and also, if the minister was able to do the calculation for \$2 a week on 4.84, do the calculations for all of them beside the table for an average family and an average single? The minister has obviously done a calculation for 4.8, but can we get it from three to the 8.53 and do a table for us?

Mr Stuart: That sounds simple, but it is not.

Senator DASTYARI: Why not?

Mr Stuart: Because each of these insurers have a wide range of policies at different prices.

Senator DASTYARI: But we are saying an average based on the average figure.

Mr Stuart: It is a percentage increase, but there are going to be a wide range of actual values of policies that are paid. We will take it on notice and we will see what we can do.

Senator DASTYARI: How did you get the other figure?

Mr Bowles: It is on the average of everything, and every one of the people that are in there. Every single insurer has an average across their portfolio, but they then have a number of people who are insured with them.

Senator DASTYARI: And I am saying: can you supply the average?

Mr Bowles: We will provide that. We will also put it in the context of the numbers in each of these funds.

Senator DASTYARI: How much have premiums gone up since 2014? Why don't we go year for year: 2014 was?

Mr Stuart: It was 6.2 per cent.

Senator DASTYARI: And 2015 was?

Mr Stuart: It was 6.18 per cent.

Senator DASTYARI: And 2016 was?

Mr Stuart: It was 5.59.

Senator DASTYARI: And then?

Mr Stuart: And 2017 was 4.8.

Senator DASTYARI: I am just doing the maths—is that about 23?

Mr Stuart: I do not think you can just add them together.

Senator DASTYARI: You have got to compound them, so it is even more than that?

Mr Stuart: Yes.

Senator DASTYARI: Okay. Can you do that for me?

Mr Stuart: On notice, we can.

Senator DASTYARI: In Treasury, I once had Dr Gruen who was actually doing the calculations himself.

Mr Stuart: I am not going to do that at the table, not with my calculator.

Senator DASTYARI: Can you take that on notice? You are right it will be higher than 23 per cent. Also, can you apply that to whatever the amount is—which is, off the top of my head, about 26 per cent—and then also apply that to what the average is, going back to that same question about what is an average increase and what an average person is paying? Can you do calculations on that as well? It sounds like you are saying the individual 34 might be harder, but doing the overall average is quite easy because it is everyone.

Mr Bowles: Yes.

Senator DASTYARI: The government said that the privatisation of Medibank will put downward pressure on premiums. Medibank, as you know, was floated in November 2014; the Department of Finance kind of ran it. Have premiums gone down since then?

Mr Bowles: I think the average increases have reduced since 2014 or thereabouts. The 4.84 is the lowest increase since 2006.

Senator DASTYARI: Have Medibank premiums gone down?

Mr Bowles: I do not think we can go specifically to what happened with Medibank Private but if you look at the last two years they have gone down.

Senator DASTYARI: Sorry?

Mr Bowles: The average increase has gone down in the last two years. The rate of increase, yes.

Senator DASTYARI: The rate of increase. It has not gone down; it is still going up.

Mr Bowles: As does everything in the economy.

Senator DASTYARI: Well, no. Everything in the economy goes up—

Mr Bowles: In the gross domestic product of the country, yes, this is increasing at a greater rate, but it has reduced in the last two years. The rate of growth has reduced in the last two years, not anything else.

Senator DASTYARI: Sure, because it was exorbitant.

Mr Bowles: I am not saying that.

CHAIR: Questions and answers.

Senator DASTYARI: Is the increase in cost of private health insurance a problem in your opinion?

Mr Bowles: Sorry, Senator?

Senator DASTYARI: Is it a problem?

Mr Bowles: Is what a problem?

Senator DASTYARI: The increase in costs of private health insurance?

Mr Bowles: I am not describing anything as a problem. It is an issue that it is growing at a rate and if you look at health growth over time it is growing at roughly the same rate. Worldwide, if you look at OECD growth we are about the middle of the pack as far as growth.

Senator DASTYARI: That is quite a political question so I will ask you, Minister. Is the increase in the costs of private health care a problem?

Senator Nash: I think the minister has made the very good point that in terms of the increase in the rate it is the lowest we have seen in 10 years. I think that is a good thing. I think that is appropriate. We have to be cognisant of the fact that private health insurance is very important for people and I think it is important to note that it is the lowest in 10 years.

Senator DASTYARI: But that was not the question. I note that the increase is lower than it has previously been and I think by all accounts would be a good thing. If we are looking at aggregation over the past few years of somewhere around 25 or 26 per cent on struggling family incomes how can it not be a concern for the government?

Mr Bowles: The government and the minister have actually got a committee process around looking at private health insurance. That has been around now for quite a while now, Senator. There were some changes to prostheses late last year, which had an impact in the sector, but there is a broader review activity happening around private health insurance at the moment.

Senator DASTYARI: I am questioning whether you are aware of this and if you are not then you can take it on notice, has any insurer reduced their premiums?

Mr Bowles: We will take that on notice.

Senator DASTYARI: Okay. In the past year has anyone gone backwards?

Ms Jolly: We would have to take that on notice because we deal predominantly in averages and you are asking a question about premiums, so we would need to have a look at the data.

Senator DASTYARI: Have any of the averages of the any of the 34 funds last year been negative?

Ms Jolly: No.

Senator DASTYARI: Are you aware of them ever being negative?

Mr Bowles: I think if you go back in time there probably have been some that have actually been flat or maybe minor reductions, but you would have to go back in time and you would have to determine what the implications were over time.

Senator DASTYARI: But in the past few years you are not aware of any?

Mr Bowles: No. But, as I said, this is the lowest in 10 years.

Senator DASTYARI: Some health insurers, and I note not all, are making some very, very large profits which obviously you are aware of. Medibank just announced a net profit of \$232 million over six months, so roughly half a billion dollars a year if they were to continue that. Minister, are you concerned about excess private health insurance profits while premiums are going up?

Senator Nash: Senator, I think we need to focus on what is in front of us and not adversely react to things in commentary. It is important, and I will reiterate, that it is the lowest rise that we have seen in 10 years. It is a bit ironic coming from you given that Labor cut \$4 billion from the private health insurance rebate for consumers and means tested it, Senator.

Senator DASTYARI: Did you reverse that or did you just take the savings? I am just wondering. I must have been sick that day!

Senator Nash: No, I must ask why you did it in the first place.

Senator DASTYARI: If it was such a bad policy why did you keep it?

CHAIR: Order!

Senator DASTYARI: We can both play this game, Minister. Where I think we are in an odd space here when it comes to private health insurance—and I think the Senate and the committee should do more work in this area—is that from publicly available data, and I am going to see what I can get from APRA here, it appears that a third of their income sources of private health insurances come from the private health insurance rebate and the rest comes from other customers. To what extent has the department put pressure on the private health insurers to reduce their premiums in return for the other policy settings the government has?

Mr Bowles: I am not sure I am going to answer that question. I do not understand what you mean by 'the department put pressure on'. We do not pressure anybody.

Senator DASTYARI: So, effectively, they can set their own policies.

Mr Bowles: Yes, which goes through the APRA process and ultimately is approved by the minister.

Senator DASTYARI: How does the approval process by the minister work?

Mr Bowles: The minister can approve or reject the increase.

Senator DASTYARI: Which minister does that?

Mr Bowles: The health minister.

Senator DASTYARI: At the end of the process is there a form or a letter. How does it—

Mr Bowles: The department will provide advice to the health minister based on what the process has been through insurers coming in and going through the APRA process. Then, ultimately, it is a decision of government.

Senator DASTYARI: Is it a decision of government or a decision of the minister, meaning—

Mr Bowles: The minister makes a decision on behalf of the government.

Senator DASTYARI: But is it a cabinet process?

Mr Bowles: No, it is the minister's decision.

Senator DASTYARI: You know how sometimes the environment minister has linear responsibility for approval—

Mr Bowles: It is the minister's decision on behalf of the government.

Senator DASTYARI: Does the minister then have the opportunity to go back to the insurers and say, 'This is too high'?

Mr Bowles: The minister has the ability to accept or reject—

Senator DASTYARI: That is it. They do not negotiate—

Mr Bowles: That is the minister's job. Does the minister have the ability to go back and talk to insurers or to say to insurers, 'Is that your best and final?' I suppose the answer would have to be yes.

Senator DASTYARI: Has the minister done that?

Mr Bowles: I am not aware. Has the minister done that?

Ms Jolly: Yes.

Mr Bowles: And former ministers have as well.

Senator DASTYARI: I will finish this up on notice.

Mr Bowles: If I could just clarify, the former minister I was talking about in relation to going back to insurers in the last round, I am not aware that that happened this time.

Senator DASTYARI: Of course.

Mr Bowles: And that was on the public record.

CHAIR: We will now return to program 4.3.

Senator WATT: I would like to turn to the review of the Life Saving Drugs Program. In last year's portfolio budget statement the department wrote:

The independent Reference Group has presented its final report of the review which will be published in 2016.

Did that happen?

Ms Shakespeare: No.

Senator WATT: Why not?

Ms Shakespeare: It is still under consideration by government.

Senator WATT: Do we have an expected time frame for completion?

Ms Shakespeare: It raises a number of very complex issues—the funding for life-saving drugs—and those are being considered across government.

Senator WATT: That has been a pretty constant refrain today, hasn't it? Things do raise complex issues, but obviously people are depending on this review being completed. When does the Department of Health plan on publicly releasing the outcomes of the LSDP post-market review?

Ms Shakespeare: I should be clear that while that review is under consideration the Life Saving Drugs Program is continuing to operate and is providing access to live-saving

medicines for patients who require them. The date for publication of the review is a matter for consideration by government.

Senator WATT: But in the meantime there are life-saving drugs not being listed that could be, as the name suggests, saving lives. Is that correct?

Ms Shakespeare: No, the listing applications are continuing to be received by the department and managed according to the existing program guidelines.

Senator WATT: Beyond complex issues, are there any other reasons for the delay in releasing the outcome of this review?

Mr Stuart: It is under consideration by government.

Senator WATT: Does that mean that something has been provided to ministers for consideration?

Mr Bowles: It is under consideration by government.

Senator WATT: By ministers?

Mr Bowles: By ministers—that is the way the system works.

Senator WATT: So you have provided advice and recommendations to ministers?

Mr Stuart: There has been a report of the review. It has been accompanied by a process of advising from the department over a period of time, and the government is considering the issues.

Senator POLLEY: Has that happened before—

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

Senator WATT: Could we request a copy of that report?

Mr Bowles: It would not be the normal process when we are advising government, because of the complexities.

Senator WATT: Could you take that on notice?

Mr Bowles: We will take that on notice.

Senator WATT: If there is a public interest immunity to be claimed we are happy for that—

Mr Bowles: We will take it on notice.

Senator POLLEY: The former minister had that in her in-tray back in October last year. Is it in the in-tray of the new minister currently?

Mr Bowles: I cannot answer that.

Senator POLLEY: Was it handed over? One would assume that if it was before the former minister you would have, on the oncoming minister—

Mr Bowles: Clearly, the new minister will be dealing with that. He will consider that in the fullness of time.

Senator POLLEY: Was any priority given by the department in the recommendation for the new minister to deal with it?

Mr Bowles: Again, it is advice to the minister around how to deal with these sorts of issues. Ultimately these are government decisions, not departmental decisions, about how

they play out. I think it is important, as Ms Shakespeare said, that the program is still proceeding under the current guidelines.

Senator POLLEY: Senator Nash, having been a minister and part of health, formerly, do you have anything to add in terms of the priority and the urgency for a decision on this review to be made by your government?

Senator Nash: I am not aware, but I can take it on notice for you.

Senator WATT: Is any of the delay in completing this review due to the actions or opinions of other government agencies?

Mr Bowles: I think other government agencies will always have views on things, particularly the central agencies. I do not know anything specific at this particular point, but it has to be a decision of government before it actually gets into that sort of policy context.

Senator WATT: Ms Shakespeare, it sounds like you are pretty involved in this. Have any other government agencies either asked for this to be put on hold or in any other way delayed progress with this review?

Mr Bowles: Other government agencies do not ask for our things to be put on hold. It is with the minister for consideration. If your question is: are other agencies interested in the outcome? which is what I thought you asked before, the answer will be, yes, places like the Department of Finance and Treasury will be interested in these sorts of programs. Let us just reiterate, though, that the program is still operating as it always has under the current guidelines.

Senator WATT: On that, Ms Shakespeare, I think you said that the program goes on and new drugs are being listed. Have any drugs been added to the Life Saving Drugs Program in, say, the last 12 months?

Ms Shakespeare: Yes. A drug with the brand name Orfadin and the chemical name nitisinone was listed in 2016. That is for the treatment of hereditary tyrosinemia type 1.

Senator WATT: Is that the only one that was listed in 2016?

Ms Shakespeare: In the time frame that you requested.

Senator WATT: That was the only one in calendar year 2016?

Ms Shakespeare: That is correct.

Senator WATT: And there have been none so far in 2017?

Ms Shakespeare: That is correct.

Senator WATT: When the Life Saving Drugs Program criteria for funding therapies for rare diseases was established by PBAC in July 2012, there was a criterion in section A) that there be evidence acceptable to the PBAC—and I have temporarily forgotten what that acronym stands for.

Mr Bowles: Pharmaceutical Benefits Advisory Committee, an independent body.

Senator WATT: The criterion states:

... that is there is evidence acceptable to the PBAC to predict that a patient's life will be substantially extended as a direct consequence of the use of the drug ...

But we looked at your department's website now and it states that criterion as:

There is evidence to predict that a patient's lifespan will be substantially extended as a direct consequence of the use of the drug.

The point is that the reference to evidence being acceptable to the PBAC has been removed. When was that criterion changed?

Ms Shakespeare: The Life Saving Drugs Program is a separate medicines funding program to the PBS. The Pharmaceutical Benefits Advisory Committee has statutory functions relating to the PBS. The Life Saving Drugs Program is administered separately and it has program criteria as set out on the website. The role of the PBAC in the Life Saving Drugs Program is that medicine must have been considered by the PBAC for listing on the PBS and been rejected by the PBAC before it is considered for listing on the Life Saving Drugs Program. So it is not actually a function of the PBAC to provide advice or decide whether or not a medicine is included on the Life Saving Drugs Program.

Senator WATT: I accept that, but it seems that, at least back in July 2012, they did have a role in this process in that it was their role to determine whether there was evidence acceptable to them to predict that a patient's lifespan will be extended. Do they no longer have that role?

Ms Shakespeare: They do not have that role, no.

Senator WATT: But they did back in 2012?

Ms Shakespeare: They do have that role in relation to considering whether or not medicine should be listed on the PBS.

Mr Stuart: Their role is about the PBS, not about the Life Saving Drugs Program. We do not have in front of us what you do, so I think we might have to take on notice that specific quote and understand where it came from and when and in what context.

Senator WATT: That is fair enough, but are you saying that to your knowledge the PBAC has never had a role in these decisions around life-saving drugs?

Ms Shakespeare: I was describing the program as it operates now. I think we would need to go back and look at documents from 2012.

Senator WATT: Okay. Assuming it has been changed and that they no longer have that role, I would like to know when that changed, why, whether any evaluations were ongoing when this criteria was changed, whether you consulted with stakeholders and notified stakeholders before making that change and whether you notified companies who had ongoing evaluations before that change was made—assuming a change was made.

Mr Stuart: My recall is that the PBAC was at the time invited by the minister to provide some advice about the LSDP criteria to the minister. I do not believe that the PBAC was itself ever involved in deciding or recommending whether a medicine should go onto the Life Saving Drugs Program. It may, however, have been asked for policy advice about the nature of the criteria. We need to take that on notice and understand that a little bit better before we venture too many answers on this.

Senator WATT: Thank you. I would like to ask some questions about a particular drug that I understand is currently waiting for evaluation for the Life Saving Drugs Program, and that is a drug called Vimizim. I understand that drug is very helpful for the treatment of a genetic condition called morquio A. That is the use of this drug?

Ms Shakespeare: To treat morquio A syndrome; that is correct.

Senator WATT: And what is morquio A syndrome?

Ms Shakespeare: It is a rare condition where the person affected has a deficiency in an enzyme which can cause issues with bone and organ muscle development.

Senator WATT: Do you know roughly how many people in Australia suffer from that condition?

Mr Stuart: I do. It is approximately 20 to 25.

Senator WATT: Does it mainly affect younger or older people?

Ms Shakespeare: Younger people.

Senator WATT: As in children or teenagers?

Ms Shakespeare: It can be both.

Senator WATT: Right. I understand that Australia was the fourth country in the world to approve Vimizim for that condition. Is that correct?

Ms Shakespeare: I think that would be a question we would need to refer to the TGA.

Senator WATT: Okay. There is no dispute that it has been approved; it is just whether we were the fourth country in the world. Is that correct?

Mr Stuart: Yes. It has been approved by the TGA.

Senator WATT: Okay. I understand that more than 30 countries, including the United States, the UK, Canada and Germany, have funded Vimizim but those 20 to 25 Australians are still waiting.

Mr Stuart: We would need to look very closely into the nature of the funding systems in those 30 countries. It is sometimes claimed that countries have funded medicines when they are available through private health insurance for patients who have the right insurance, who are paying the right premiums, who do not have pre-existing conditions and so on and so forth rather than actually being part of a national health scheme. We are a little different from many other countries in having a fully taxpayer funded system for lifesaving drugs for very rare diseases that are potentially life threatening.

Senator WATT: Okay. My question was going to be why it is that more than 30 other countries fund this but not Australia, but your answer is that some of them fund it in different manners to how Australia would do so?

Mr Stuart: Yes.

Senator WATT: Have any calculations been done as to the cost of funding this?

Ms Shakespeare: We are in current negotiations with the sponsor of this medicine. I think they would consider some of that information commercial-in-confidence. I met with the company that sponsors this drug in Australia last Thursday, and they presented new clinical evidence and new proposals around listing this drug on the Life Saving Drugs Program.

Senator WATT: Are we talking millions, tens of millions, hundreds of thousands?

Mr Stuart: I would prefer not to get into that, because it might weaken our negotiating position.

Senator WATT: Okay. When do you expect that a decision will be made on Vimizim funding?

Ms Shakespeare: I do not think that we can give you an expected date. It is subject to ongoing negotiations with the sponsor of the medicine.

Senator WATT: Okay. In March 2016, the PBAC accepted the clinical effectiveness of Vimizim and referred the submission to the Chief Medical Officer, our friend Professor Murphy, to provide advice to the Minister for Health on potential inclusion on the Life Saving Drugs Program. That means that it has almost been a year since the CMO's office has had this submission. Why has there been no communication from the Chief Medical Officer or the department about the status of the submission or timing for a possible resolution?

Mr Stuart: Because it is under consideration by the government.

Senator WATT: I have a feeling we are going to hear that a few times today!

Senator DI NATALE: I have been at estimates for six years. I reckon I have heard the same answer. How long has the Life Saving Drug Program been under review?

Mr Stuart: We are talking about the listing of Vimizim at the moment, not the review of the Life Saving Drugs Program.

Senator DI NATALE: When did the review of the Life Saving Drugs Program start?

Ms Shakespeare: It was announced on 9 April 2014.

Senator DI NATALE: 2014. We are in 2017. How long does a review take? I am asking. Senator Watts probably had representation from people who are desperate, whose families are faced with these huge dilemmas of whether they pay hundreds of thousands of dollars—sometimes more—to try and buy themselves some hope. I have had similar representations for a number of years, and this program has been under review since April 2014—three years.

Mr Bowles: The program is under review, yes, on what our future direction will be, but the program still operates under its current guidelines, and medicines are dealt with in the current guideline context.

Senator DI NATALE: I might ask a few questions about that in the moment. I am sorry to interrupt, Senator Watt.

Senator WATT: I have not got much longer on this, and that is it for Vimizim. By the way, I have got references to that website. I can table them as well. One other government report we are waiting on is the government's response to the Community Affairs Reference Committee report titled *Availability of new, innovative and specialist cancer drugs in Australia*, and we are waiting on that despite an order for the production of documents being agreed to by the Senate on 13 September last year. Where is that response?

Ms Shakespeare: The then minister for health did table a response on 7 October in the Senate in response to that Senate order.

Senator WATT: Well that's good! What I am told is that October—that month—a letter from the former minister to the President said that the government was giving detailed consideration on its response and would release it in due course. You are saying that the actual response has now been tabled?

Ms Shakespeare: I think that, as the minister's letter indicated, it covered off some of the work that had been completed to date in response to some of the recommendations arising from that committee review and indicated that further work was continuing. I think the minister's letter referred to the medicines and medical devices review and the work that had been done there. Since then, there has also been further work on the Pharmaceutical Benefits Advisory Committee Guidelines, and we are continuing to work with rare cancer groups, including through a piece of work that is happening at the moment—the Cancer Drugs Alliance group—to look at our processes and how they can be adapted to ensure that they are suitable for the consideration of treatments of rare cancers.

Senator WATT: So you are saying that I will be able to have a look and find the actual response that was tabled on 7 October 2016?

Ms Shakespeare: There has been a response by the then minister, and there will be a further, more detailed response once some of this other work has completed.

Senator WATT: Okay. That is it for me on 4.3.

CHAIR: Senator Di Natale.

Senator DI NATALE: How many new drugs have been listed under the Life Saving Drugs Program this year?

Ms Shakespeare: I think the one I mentioned before—one.

Mr Stuart: This was in 2016.

Ms Shakespeare: 2016—in the last 12 months.

Senator DI NATALE: The 2016-17 period?

Ms Shakespeare: Yes.

Senator DI NATALE: So there has been one drug listed?

Ms Shakespeare: Yes.

Senator DI NATALE: What about the 2015-16 period?

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

Mr Stuart: There were three in calendar year 2015, but I am not certain whether it was in the first or second half of the calendar year.

Senator DI NATALE: I will ask you to take that on notice. Could you tell me what the spending on the Life Saving Drugs Program looks like over the last four years? Let us look at the forward estimates.

Mr Stuart: For 2015-16, it was \$97 million.

Senator DI NATALE: What is projected for this year?

Mr Bowles: It is 117, I think, Minister—Senator.

Senator DI NATALE: I got a promotion too! So we have \$117 million this financial year; \$97 million in the previous year, 2015-16—and the two before that?

Ms Shakespeare: In 2014-15, \$85.9 million; in 2013-14, \$77.3 million.

Senator DI NATALE: And we have only had one drug listed in this financial year as far as you are aware. People are very frustrated that this review has taken so long. What is the

reason for the delay? As we said before, 'It's complex,' does not really cut it. That is the Donald Trump answer to health policy. Explain the complexity to me.

Mr Bowles: It is a separate program from the PBS, and it still operates under its current guidelines.

Senator DI NATALE: Yes, but there is a lot of discontent with the way it operates, hence the review.

Mr Bowles: Yes, I accept that. These are matters that have to be considered by the minister and government.

Senator DI NATALE: Perhaps that is a question for the minister. Minister, this is a program that was flagged for review almost three years ago. Why hasn't a decision been made on this yet?

Senator Nash: I am not in a position to assist you with that, but I am happy to take it on notice for you.

Senator DI NATALE: All right. Thank you.

CHAIR: I think that concludes program 4.3 for this committee.

[12:27]

CHAIR: We will go back for round 2 on program 4.4, private health insurance.

Senator DI NATALE: I want to follow some of the line of questioning from Senator Dastyari. We are saying that the rebate is worth—was it—\$6.4 billion? I cannot remember.

Mr Bowles: For the rebate, \$6.4 billion.

Senator DI NATALE: What is the increase from the previous year?

Mr Bowles: The previous year was \$6.2 billion.

Senator DI NATALE: The year before that?

Mr Bowles: I do not have that.

Ms Duffy: \$5.9 billion.

Mr Bowles: \$5.9 billion.

Senator DI NATALE: And the year before that?

Ms Duffy: No, I only have the portfolio budget statements.

Senator DI NATALE: That is okay. So it has gone up \$300 million or so and now another \$200 million or so?

Ms Jolly: Could I just correct that: it is \$5.953 billion, so it probably rounds up. I have the accurate figures.

Senator DI NATALE: Let me ask you about the increase for premiums. The average increase overall was what figure?

Mr Bowles: 4.84.

Senator DI NATALE: 4.8? What is health inflation?

Mr Bowles: That is a tricky question sometimes because everyone has a different view, but I think it is well over five at the moment.

Senator DI NATALE: I am talking about for the period for the last increase.

Mr Bowles: If you look at the broader increases, I would suggest it is around five to 5½. I would have to take on notice the specifics of that.

Senator DI NATALE: Okay. Can I ask you about some issues. People have expressed concern about exclusions and particularly exclusions that are happening often without people even being notified. Is that something I can talk to you about? Is that right?

Mr Bowles: It crosses a couple of areas.

Senator DI NATALE: I know. Mr Sims at the ACCC said that he felt—I think these were his words—a mixture of surprise and horror after he had heard about how patients were treated by some of their private health insurers. He said:

"What concerns us is companies saying, 'Well it's too expensive to keep offering this to members, so we'll stop doing it' and not telling people ...

"So someone could have gone to hospital, enjoyed certain benefits one day, go back again and be faced with a large, out-of-pocket bill the next day.

Mr Bowles: I am not sure that we will be able to get into too much detail on what is happening with insurers.

Senator DI NATALE: What is the process? If an insurer decides to make an exclusion around their policy, what is the process there? Do they have to notify all members?

Ms Duffy: Yes.

Senator DI NATALE: How do they do that?

Ms Duffy: In written format.

Senator DI NATALE: What does that look like? Is that like, 'We'll send you a new brochure with a little asterisk'?

Ms Duffy: It is a letter. They all do it differently, but they have to set out the changes to their policy. They also have to provide a new statement of what the policy includes.

Senator DI NATALE: Is that the same with other insurance? For example, if you take out motor vehicle insurance and there is a change to your motor vehicle insurance policy, are they allowed to do that once you have taken out a policy?

Mr Bowles: I do not think we can answer that.

Senator DI NATALE: The question then is: is an insurer at the moment able to, even if you have an existing policy, say, 'We've decided we're going to change the policy and the terms of the contract which you agreed with when you took out that policy'? They can put an exclusion around anything they want while you hold that policy. We are not talking about for new people; we are talking about for existing customers. Is that right?

Ms Jolly: The legislation has a number of inclusions that are required. Ms Duffy spoke earlier about policies being in line with the legislation. While insurers are able to make changes, as you have indicated, there are a set of rules around what they are allowed to make changes to, and that is reflected in the legislation.

Senator DI NATALE: It seems to me, though, that you could have a case where insurers—and this appears to be what is happening—are making greater and greater exclusions for people who have taken out a policy. A lot of these people will not know that something has been excluded. It may be that they get a letter. I would be interested to know

what—and perhaps you could take on notice—the requirement is under the act. Perhaps you could even provide an example of what is considered to be appropriate practice for insurers in terms of notifying customers.

Ms Jolly: We can certainly take on notice what is in the legislation. I am not sure whether we could provide an example, but we can see what we can do.

Senator DI NATALE: Mr Sims went on to say:

"It is certainly surprising how these decisions are made, and particularly given the impact that they can have on vulnerable people who are in hospital or are just about to go into hospital."

How is the department responding to the concerns from Mr Sims?

Mr Bowles: First of all, the former minister and the current minister have proceeded with the review of private health insurance with the set-up of the ministerial committee structure that is actually currently meeting to look at private health insurance in the broad sense.

Senator DI NATALE: But are they looking specifically around exclusions?

Mr Bowles: That is part of what that group is looking at, yes.

Senator DI NATALE: Have you seen an increase in the number of complaints?

Mr Bowles: I have not, personally.

Ms Duffy: The Private Health Insurance Ombudsman recently released its report on complaints. The complaints go to the ombudsman.

Senator DI NATALE: Have you got that information in front of you?

Ms Duffy: I do not have a copy of that report with me. It is on the website. There was an increase in complaints, but I do not have the information.

Senator DI NATALE: Obviously, for the process for complaints, you have the ombudsman and the ACCC. I imagine they take a role. What prompts an ACCC investigation into something like this? What would prompt Mr Sims to weigh in here?

Mr Bowles: I assume that it is based on his view about the legislation. I think you would have to ask him why he has weighed in on it.

Senator DI NATALE: But there are obviously different players in this space, aren't there?

Mr Bowles: Yes.

Senator DI NATALE: There is the ACCC—

Mr Bowles: There is APRA and there is the ACCC. There is a range of different groups, yes.

Senator DI NATALE: What is the department's role in dealing with complaints about what health insurers can and can't do?

Mr Bowles: We do not deal with complaints—that is through the Ombudsman's office. Do we have a role at all?

Ms Duffy: There are some complaints for which we assist with policy advice. That is when the Ombudsman comes to seek policy advice on certain aspects they might be dealing with in a complaint.

Senator DI NATALE: Can you explain that a little further or perhaps by way of example?

Ms Jolly: If they have a matter that comes to them and they are not really sure about either the legislation or the current policy settings, they would often come to the department to ask advice in general as opposed to on a particular matter. They might come and ask what the current arrangements are under the legislation for a particular area of interest and that is the sort of role that we would play. It is information provision.

Mr Stuart: I have just been told that the ACCC conduct an annual review of private health insurance.

Senator DI NATALE: Are they doing anything beyond what they would normally do?

Ms Duffy: The ACCC process is an annual process where they look at the sector and pick up in the 12 months leading up to the release of a report things that are reported to them as part of their review. This year they focused on the type of information health insurers provided to consumers.

Senator DI NATALE: The type of information—so does that include information about exclusions?

Ms Duffy: Yes.

Senator DI NATALE: Do we have any recommendations?

Ms Duffy: I am unsure if the report has been released yet.

Senator DI NATALE: Can you take that on notice and provide that to us if possible? Are there any particular areas of concern that you are aware of? For example, I know bariatric surgery is an issue that has been raised in relation to exclusions.

Mr Cormack: As the secretary said, we have a Private Health Ministerial Advisory Council that has been established. It is a very active group of experts, chaired by Jeff Harmer. It is proceeding through a number of the very issues that you are focusing on. It is looking at the product designs; it is looking at consumer information; regulation; specific issues concerning rural and remote consumers; looking at a range of funding models for general treatment. It is also getting down into some of the detail about contracting, default benefits and standard clinical definitions. Probably the centrepiece of the work is an attempt to standardise the way that the funds describe products. The working model we have at the moment is gold, silver and bronze. The committee is working through what are considered the essential services: if one health insurer describes their product as gold would it be the same as another health insurer's description of gold? What is the range of essential services at that level? We then do the same thing for silver and the same thing for bronze. This will come back as advice to government, there are regular updates on the progress on the website, and I think we have had five meetings so far. This is an attempt to standardise the sorts of exclusions that a consumer could expect when they look at a product called gold, silver or bronze. Clearly, it will differ. To have a range of different exclusions and excesses helps consumer choice and helps them to have more affordable product. There is always a balance between comprehensiveness, affordability and—

Senator DI NATALE: I am sure most people appreciate that. But let me ask you about where bronze finishes and where junk starts. I think there is a colloquial definition of what is a junk policy, which basically exists so that people minimise their liability for the Medicare surcharge. What is the government doing about those policies, which provide no value

whatsoever to the user because they end up going into a public hospital if they need it, but they take out the policy so they do not have to pay the surcharge?

Mr Cormack: What the government is doing is attempting to find the three levels, as I described, and, by default, once that is sorted out then there is technically a residual category of policies that do not fit those three gold, silver and bronze standards. Then the committee will make recommendations to government about, if you like, where that kind of cut-off line should be, what should be acceptable levels of excesses and exclusions for each of those three bands. That work is in progress, and I cannot tell you today—

Senator DI NATALE: No, I appreciate that. Does that mean that there will be some policies that exist right now that just will not exist in the future?

Mr Cormack: Ultimately, it is a matter for government consideration and report.

Senator DI NATALE: Yes, but hang on—

Mr Cormack: The purpose of the work is to—

Senator DI NATALE: I get it.

Mr Cormack: come up with a—

Senator DI NATALE: With a standard.

Mr Cormack: much more consistent, standardised definition of products that would be complying health insurance products, and then it is a matter for government to consider how it wishes to adjust its policy settings—

Senator DI NATALE: Whether it is going to exclude some products.

Mr Cormack: and regulatory settings according to the advice that is yet to come through.

Senator DI NATALE: The only consequence of a review like that is that premiums go up. I am not saying it is a bad thing or a good thing, because we have junk policies that are of no value. But, if you are going to exclude a bunch of policies have no value for the person who purchases them other than to reduce their liability when it comes to paying the Medicare levy, then the average premium has to go up, because they are at the bottom end in terms of cost.

Mr Cormack: I think it really depends on the various descriptors that are finally settled on in terms of advice to government, against each of those levels. And junk policies do achieve a couple of things. They are affordable, but they also contribute to the overall risk equalisation pool, which reduces the overall cost to all insurers. So they do have some inherent value.

Senator DI NATALE: But, on that logic, we could have a policy that costs \$10 that covers you for being struck by lightning and nothing else.

Mr Cormack: The government, at the end of the day, can determine what is a compliant product, and the advice that will come forward from the ministerial advisory committee will assist government to be able to modify its various policy settings to ensure overall affordability, transparency of product and value for money, and also to minimise the risk of any overall increase in premiums.

Senator DI NATALE: So at this stage you have made no decision about whether you are going to restrict some policies as they currently exist?

Mr Cormack: The work of the committee is well advanced, but they have not provided any interim or final report to government at this point in time, and that work will continue throughout this year.

Senator DI NATALE: What about work around treatment in public hospitals?

Mr Cormack: That is a matter that has been discussed—it has been raised by both the private hospital representatives and the private health insurance representatives—and that would need to be considered in the overall context of where private health insurance goes and how it is described in terms of products, once government gets to consider that. It also has a crossover point into the public hospital funding agreements, which clearly are a complex matter in their own right. There is nothing in the current arrangements either for private health insurance or through public hospitals that prohibit a person from electing to come in as a private patient and using their insurance accordingly.

Senator DI NATALE: Sure, but you are considering whether that should change?

Mr Cormack: We have had a lot of advice from the various members of the group. They will be putting forward a comprehensive piece of advice to government. But that specific area is not something that is within the purview of the Commonwealth alone to determine. It would clearly be an area of interface with the state and territory governments in the context of the COAG National Health Reform Agreement.

Senator DI NATALE: But you will be making a recommendation. I suppose what I am saying is, is that something you are not looking at, or is it something that you are actively looking at?

Mr Cormack: It is something that has been raised and discussed. At the end of the day, we will wait for the private health insurance ministerial advisory committee to put forward its recommendations. The government can then consider—

Senator DI NATALE: But you are not ruling that out as a possibility?

Mr Cormack: I am not pre-empting what the committee is going to advise the government. They have got reasonably broad terms of reference, and they are a very skilled and expert group. The government has asked for their advice. They will give their advice, and the government will consider it accordingly. If it has knock-on effects or issues that it cannot decide within the context of private health insurance regulation arrangements, then it will need to consider it in the context of Commonwealth-state funding arrangements for public hospitals.

Senator DI NATALE: One thing we did not ask about is private health insurance coverage. Can you give me, firstly, the top-line figures around that, and whether you have broken those down in any way?

Ms Duffy: Coverage of hospital?

Senator DI NATALE: Yes; how do you stratify it?

Ms Duffy: The APRA quarterly statistics were released in February. As at December 2016, the number of people with hospital cover was 11,327,512.

Senator DI NATALE: What is that as a percentage of the population?

Ms Duffy: It is 46.6 per cent.

Senator DI NATALE: How does that compare to previous years?

Ms Duffy: The previous year or the previous quarter?

Senator DI NATALE: I do not mind if you want to give me quarterly figures, but I want to go back a few years.

Ms Duffy: The previous year was 47.2 per cent at the same time.

Senator DI NATALE: And the year before that?

Ms Duffy: I do not have that with me.

Senator DI NATALE: Could you get that on notice? So there has been a significant decrease in coverage from December 2015 to December 2016?

Ms Duffy: That is for hospital treatment—

Senator DI NATALE: Yes.

Ms Duffy: and then for general treatment, as at December 2016, the number of people with general cover was 13,463,257, which is 55.4 per cent.

Senator DI NATALE: And compared to the year before?

Ms Duffy: It was 55.8 per cent.

Senator DI NATALE: So another decrease in coverage. Is that part of a broader trend, or is that something you cannot tell me until you have broken down the figures according to previous years?

Ms Jolly: We can provide you with the previous data.

Senator DI NATALE: Would it be an accurate assessment to say that it has been trending down over the last few years?

Ms Duffy: Only slightly; it has been pretty stable, around those figures.

Senator DI NATALE: There is a 0.6 per cent decrease in hospital coverage and a 0.4 per cent decrease in general coverage. Can I ask you—and take this on notice, perhaps—for the figures over a five-year period? Can I also ask you about the level of coverage, and changes in terms of coverage? Is that information you have?

Ms Jolly: No, I do not think so.

Senator DI NATALE: Obviously one of the concerns is people downgrading their coverage—this is a global number. How do you collect that information?

Ms Duffy: Changes do not necessarily mean downgrading. There are a range of reasons why people might change.

Senator DI NATALE: So amendments, yes?

Ms Duffy: I do not have the information on amendments with me, sorry.

Ms Jolly: There is a report that actually contains all of the statistics that we are quoting you. It was released on 14 February. It has quite a lot of data on PHI. The figures that we are quoting today come from that report, and that report may have some further detail.

Senator DI NATALE: What is the report?

Ms Jolly: It is a report from the Australian Prudential Regulation Authority.

Senator DI NATALE: I will still ask you, if you can, to look at amendments, and if you can give me some information on that as well. I will chase up that report.

One last question: costing is going up—this is perhaps one for you, Mr Bowles. The rebate is going up—it is now worth \$6.4 billion—and it continues to go up. Premiums continue to go up. Exclusions continue to increase. We have got people—and we will confirm this—amending cover to downgrade cover. This seems like a spectacular failure of public policy given that the primary intent of the policy is to try and take the pressure off a public hospital system. It has failed at that. How is this a sustainable health policy?

Mr Bowles: You used a lot of emotive words in that question, which I am not going to address. I think the fact that we have the private Health Insurance Ministerial Committee chaired by Jeff Harmer going through all of the issues that we have canvassed here today is evidence that we obviously think we need to have a look at this in the broad. That is what is happening and that has been the government decision. Clearly, if you do see all of those increases and decreases in the varying factors that we have been talking about, it is time for us to have a look at this and we are.

Senator DI NATALE: I just do not know why a consumer would take it out. Apart from minimising your tax liability, it seems like a total waste of money.

Mr Bowles: I think that there have been year-on-year increases over the last 10 to 15 or so but it has flattened off, and benefits paid from insurers keep going up so there are reasons for people to do this. There have been significant policy changes over the last 15 years or so that have seen quite significant changes.

Senator WATT: I must have missed miss this but I take it we are into outcome 4.4?

CHAIR: That is correct.

Senator WATT: I just have one final set of questions. I have got copy of this article that was in *The Weekend Australian* on 11 February written by Sean Parnell. I do not think we have covered this issue already. It is entitled: Leave price rises to us to decide, private health insurers tell Greg Hunt. That report says:

Health insurers would be allowed to raise their premiums without the need for federal government approval, under a contentious proposal to be put to Health Minister Greg Hunt.

It goes on to say:

... the Private Health Ministerial Advisory Committee is set to recommend Mr Hunt leave future price hikes to the companies and market.

I note Mr Parnell obtained copies of minutes of a committee meeting and that committee seems to include representatives of the Department of Health. Has that recommendation been made by the Private Health Ministerial Advisory Committee?

Mr Bowles: The committee has not reported in its final form at this stage. This is based on information, obviously, that a journalist has received. There are no recommendations before the minister on this yet. The committee is still considering how it might proceed with all of those things.

Senator WATT: Who was the departmental representative on that committee?

Mr Cormack: We have a number. Mr Maskell-Knight is the most senior regular member of that. I attend regularly and we have another of number of other officials from medical

benefits division as well, so there are a number of people who contribute. It is chaired by Jeff Harmer, but most of the discussion around the table is really from non-government representatives.

Senator WATT: So, Mr Bowles, I think what you said was that the committee has not provided a final report to the minister?

Mr Bowles: It has not provided a report at all in any shape or form.

Senator WATT: So no drafts, no interim, nothing at all? No recommendations?

Mr Bowles: They are in the deliberative phase of collecting information. Everyone has a view, as you would imagine, that is in the melting pot and it will ultimately be something that goes to the minister.

Senator WATT: And then we will get to the famous 'under consideration by government' phase after that?

Mr Bowles: That is possibly true.

Mr Cormack: Just to be clear, after each meeting there is a summary of the meeting that is published on the website. So the material that Sean Parnell has managed to access is publicly available material. And that material is also provided to the minister so that he gets a feel for what happens at each of the meetings. You can follow the colour and movement through the website but you will see that there are no recommendation, no report. It is simply a summary of what is going on, and that is what Sean Parnell has picked up on.

Senator WATT: I haven't seen that on the website, but it is likely that he is quoting directly from something that is on the website.

Mr Cormack: Yes.

Senator WATT: So there is no Bob Woodward, after all.

Mr Cormack: No.

Senator WATT: Not on this report anyway.

Mr Cormack: No. He is good on other stuff.

Senator WATT: So I take it that this potential for deregulation of health insurance premiums has been discussed at the ministerial advisory committee.

Mr Cormack: Yes.

Senator WATT: When do you expect there will be a report or recommendation made to the minister?

Mr Cormack: Probably in the second half of this calendar year.

Senator WATT: I see that the minutes of this meeting record that most members were in favour of deregulation. Is that an accurate reflection of the meeting?

Mr Cormack: I might ask Mr Maskell-Knight to comment. I do not think I was actually physically at that meeting.

Mr Maskell-Knight: I think that is a fair summary of the meeting.

Senator WATT: What position did the Department of Health put at that meeting?

Mr Maskell-Knight: The Department of Health did not have a position.

Senator WATT: So the Department of Health has not expressed a position?

Mr Maskell-Knight: To the best of my knowledge and recollection. I did not say that the department believed one thing or the other. I am there as the head of the secretariat to the committee, and while I provide advice about factual issues I try to refrain from engaging in the debate. It is a forum for the industry associations, consumers and others.

Senator WATT: Is there any representative of the department at that advisory committee who performs more than a secretariat-type role?

Mr Cormack: The times that I attend I actively get engaged in the discussions, as indeed does Mr Maskell-Knight. Often times a discussion goes down a path where there is a departure from the factual basis, a departure from an understanding of the regulation or a departure from understanding some of the issues. So what we will do in those instances is provide the necessary factual information, provide government policy guidance. The government has very clear policy positions on private health insurance, and they all help to contribute to the discussions. But our job is to provide good quality material and to support this very expert group to consider the issues, to be able to summarise them and eventually to formulate a series of recommendations to government.

Senator WATT: Has the department provided any advice to the minister on these suggestions that health insurance premiums should be deregulated?

Mr Cormack: In the context of the work that is underway at the moment, we have not provided any formal advice that suggests things should be done one way or another. But the minister is very interested in all aspects of his portfolio, and we have clearly discussed with the minister a number of elements of health insurance, including how premiums get set.

Senator WATT: Have you discussed with the minister or his office an option of deregulating premiums?

Mr Bowles: I think we would wait until this committee finalised its deliberations, because they may choose not to go down that path. They may think it is not the wisest thing to do. We do not—

Senator WATT: I understand that. I completely understand that. And I understand the advisory committee is probably independent of the department. I am just picking up on what Mr Cormack said, which is that you do from time to time have discussions with the minister about private health insurance and what can be done around premiums. So I am asking whether—and I am not saying it is a great idea or a bad idea—the deregulation of premiums has even been discussed.

Mr Cormack: The best way I can answer that is that the minister has been appointed relatively recently and we have had a great opportunity to provide the minister with a lot of information about the breadth and depth of his portfolio responsibilities. In the course of that, the minister seeks information about all manner of things: pharmaceuticals, MBS, private health insurance. He needs to understand what his responsibilities are under legislation, and we discuss all manner of things. But, in terms of whether we have given directive advice to the minister in relation to the work of this committee, we have not, because the committee is still undertaking its deliberations. As I understand it, the chair has had at least one formal discussion with the minister, and that was a matter of discussion between the chair and the minister. Certainly, the department was not involved in that.

Senator WATT: I am very clear from what you have said that you have not provided formal advice to the minister about a possible deregulation of premiums. But the way you have answered that question leads me to think that this possible deregulation of premiums is something that has been discussed in a broad sense.

Mr Cormack: I think it is speculative.

Senator Nash: I would not make assumptions.

Senator WATT: You have not ruled it out.

Senator Nash: Perhaps I can assist, Senator. I would not make assumptions on that basis, and I think you would accept that, very newly in the portfolio, the new minister would be accepting a whole wide range of advice in terms of this review. You would expect the review to canvass a whole wide range of issues in the context of a review. That is what they are there to do. But, as we have said, that has not as yet reported to the minister, and I think people would expect the new minister, with new feet under the desk, to canvass as many options and areas across his portfolio as possible.

Senator WATT: Including potential deregulation of premiums.

Senator Nash: No, I think you are trying to assume that it is a particular issue, and I would not categorise it as that at all. I think the officials have been very clear in saying that a wide range of issues have been discussed with the new minister, as you would expect.

Senator WATT: Has the department ever done any modelling of what impact deregulation of premiums would have on premiums?

Mr Cormack: No.

Senator WATT: It has never been modelled?

Mr Cormack: Certainly not as part of this body of work, and I am not aware of any work that has been done.

Senator WATT: I might get you to take that on notice, just to be really thorough.

Mr Bowles: We can categorically say: as part of this process, no.

Senator WATT: I am interested more broadly in whether that work has been done.

CHAIR: Does anyone have further questions? If not, we will move to program 4.5: medical indemnity. Does anyone have questions on this? If not, we will move on.

Senator WATT: I was asking about the Life Saving Drugs Program earlier. I have not got printouts of your website, but I have got something that I understand is taken from the website. That might be useful as you attempt to answer those questions on notice, so I will table those.

Mr Bowles: Thank you.

[13:03]

CHAIR: We are moving to program 4.6: dental services. I suspect we will be continuing after the lunch break with this.

Senator WATT: Initially, I have some questions about the Child Dental Benefits Schedule. I was very pleased to see that on 8 February the minister backed down on the

proposed cut to that scheme, which is very important for kids in Queensland and right across Australia. Did the department provide any advice on that backdown?

Mr Bowles: Again, your characterisation of the issue is not appreciated from an official's perspective. We provide advice to the minister on policy decisions that he, in this case, made in relation to changes to the Child Dental Benefits Schedule.

Senator WATT: I understand that it is a political decision as to whether to back down or not, but did the department provide any advice recommending that the minister not pursue those proposed cuts?

Mr Bowles: The department provides broad advice on policy directions and the minister, as the policymaker, will make those decisions.

Senator WATT: And did your advice recommend that those cuts not be pursued?

Mr Bowles: Again, it is advice I provide to ministers. There are a whole range of things that go into the mix of advice to ministers. We, as officials, are not policymakers in this context. It is the minister and the government that make these policy decisions.

Senator WATT: Prior to the 8 February, when was the last time that the department provided advice to the minister on the Child Dental Benefit Schedule?

Mr Bowles: I would have to take it on notice, but it was probably not long before 8 February—if that was the date.

Senator WATT: Do you recall having any discussions yourself with the minister about this?

Mr Bowles: Yes.

Senator WATT: When were those—

Mr Bowles: Probably the day of, the day before and the day before that. It was one of those things that we obviously had a conversation about.

Senator WATT: So you provided the minister with advice, probably on the day or potentially the day beforehand about this issue?

Mr Bowles: Or in the days leading up to it. I would have to take it on notice. It would be in the days leading up to it and, we would have had a conversation about possible options.

Senator WATT: The reason I am asking is that on 7 February, the Labor Party confirmed that we would move to disallow that cut being made. Is that why the minister backed down the next day?

Mr Bowles: I am not going to answer that question.

Senator WATT: Perhaps Senator Nash can answer that.

Senator Nash: I think you would understand that the minister had been giving due consideration to this and arrived at the policy change that he did.

Senator WATT: So it is a coincidence that the government had been talking about cutting the Child Dental Benefit Schedule for almost a year and then backed down the very day after Labor secured crossbench votes to block the cut?

Senator Nash: Ministers make decisions around policy changes on sensible advice and after due consideration and not, perhaps as you would like to assume, through decisions and actions of the Labor Party.

Senator WATT: The very next day is pretty remarkable timing, isn't it?

Senator Nash: That is an observation, Senator.

Senator WATT: I had my press release ready to go.

Senator Nash: It is an observation.

Senator WATT: Mr Bowles, are you aware of a letter about this scheme—and, again, I can table this—that the human services department wrote to eligible families on 9 February?

Mr Bowles: I am aware they write to people who are eligible because that is their job, but I am not specifically aware of the letter itself.

Senator WATT: We can probably get a copy to you. I will read some to you while we are getting a copy to you. It is dated 9 February 2017, the day after the government backed down on the cuts.

Senator Nash: If I may, Senator, I would not say it was a backdown.

Senator WATT: How can it be anything else?

Senator Nash: No, no. The minister made a policy change—

Senator WATT: Backflip. We would prefer backflip.

Senator Nash: Hang on, Senator. The minister made a policy change and, might I add, it was after consultation with the Australian Dental Association.

Senator WATT: I met with the Australian Dental Association about this very issue in the days leading up to this, so I am aware—

Senator Nash: Good for you! Excellent.

Senator WATT: they were strongly opposed to this cut all along. I am sure—

Senator Nash: I think it is important to note that the minister was working closely with the Australian Dental Association and then arrived at the decision that he did.

Senator WATT: There are a few other things where it would be good if he listened to them as well. In this letter, dated 9 February 2017, the day after the minister's policy change, as opposed to a backdown—

Senator Nash: Thank you, Senator.

Senator WATT: I do not have the name of the person it was written to:

Your children's eligibility for dental benefits.

Our records show that the children listed below are eligible for dental benefits in 2017 under the Child Dental Benefit Schedule. This means you are able to access benefits for basic dental services for your children up to a capped amount over a two calendar year period. This two-year cap period starts from the calendar year in which the child first receives an eligible dental service.

Then it goes to talk about changes being made to the capped amount, being the reductions and the cuts that were intended to be made, until 8 February. So we have a letter being sent to people by the Department of Human Services on 9 February, the day after the minister announced his policy change/backdown—

Senator Nash: No, it just follows the change.

Senator WATT: which is the day after Labor confirmed that we would move to disallow and we had the numbers to do so. But the letter advises that the cap is \$700, not the full \$1,000. Why would that have happened?

Mr Bowles: That is probably a question best asked of the Department of Human Services. However, given the scale of the exercise I would suggest that this was in train prior to the final policy decision of the minister on 8 February, as you pointed out, and it probably just did not stop the machinery moving that out. When you write to so many people, that is what happens. That would have been prior to that and my understanding is that Human Services would have corrected that by now. Again, you could ask them a little bit more about that.

Senator Nash: And just to make it clear: the updated figures will go out in writing so that everybody understands their entitlements—or they have gone out; I will need to check with Human Services as to whether they have gone already.

Senator WATT: But there might have been another letter go out.

Senator Nash: But of course the updated figures would go out.

Senator WATT: Was the health department consulted on the preparation of that letter?

Mr Bowles: We would have at the time. It was probably following the previous decisions, and it is their job to actually write to people. As I said, they would have had this in train and then circumstances changed.

Senator WATT: That is not quite my question. My question was whether—and not 'would have'—the health department was consulted about the preparation of that letter.

Mr Cormack: We are the policy department, and it is our job to ensure that DHS is implementing government policy. And, as Mr Bowles said, there was a decision taken prior to the minister's policy change. Steps were in train. And obviously there was a timing issue, and some letters got out. I think you can probably talk to the Department of Human Services about the precise circumstances of that. But the point is that whatever was sent in error has been stopped. The process of reissuing letters is underway. And you would have to take the details of that up with DHS. And the web pages of the department's website were updated after the new decision was taken by the minister.

Senator WATT: You do accept, though, that the fact that the letters were being sent out on 9 February, the very day after the minister announced something, and they are saying something completely different to what was announced the day before, does lend weight to the suggestion that this backdown or policy change was made very close to the time it occurred, on 8 February?

Mr Bowles: Well, that is not something I am going to answer. That is a policy decision of government. What I made very clear is that the minister—

Senator WATT: I mean, these letters were not produced six months before and waiting in someone's out-tray; they were—

Mr Bowles: No, but they do take some time, and the policy at the point when that would have been developed was as it is described in that letter. There is a process. These go out to quite a number of families obviously across the country. It would have been in place, and then the minister made a policy change, and that has subsequently been implemented.

Senator WATT: And in fiscal terms, how much will the government's policy change cost in each year of the forward estimates?

Mr Cormack: That matter will be brought to bear in the budget context, so—

Senator WATT: But you must have those figures there.

Mr Cormack: No—well, estimates were updated in MYEFO, and the cost of this change will be brought to account in the budget.

Senator WATT: But those estimates that were published in MYEFO would have assumed that the cuts had gone ahead. The minister surely cannot go out and make an announcement without knowing what it is going to cost.

Mr Cormack: Well, the minister has made a policy decision. He is entitled to make a policy decision. And we provide advice on a range of matters in the lead-up and the follow-on from those policy decisions.

Senator WATT: Did you provide advice on what that change would cost?

Mr Cormack: There would have been some information provided to the minister. I do not have that information with me.

Senator WATT: Could you possibly get that for us over the lunch break?

Mr Bowles: We will take on notice what we can and cannot provide, in the context of the budget.

Senator WATT: It cannot be a secret. It cannot be too hard to work out what that is, and you should be able to come back to us about that today.

Mr Bowles: Well, it depends. If it is in the context of the budget, which it is, that is not normally released until a Tuesday in May.

Senator WATT: So, we cannot ask questions about what announcements that have already been made will cost? We have to wait and see what they cost in the budget?

Mr Bowles: As I said, I will take it on notice.

Proceedings suspended from 13:15 to 14:15

CHAIR: We will reconvene and carry on with program 4.6, dental services.

Senator GRIFF: My first question relating to the Child Dental Benefits cap is: have you revised the target for the number of children expected to use the service in 2016-17?

Mr Cormack: We do not actually have targets. There is an eligible population. That is defined by their benefit status, or their family's benefit status. We do the necessary notification through DHS.

Senator GRIFF: Mr Cormack, how do you not have targets when your annual report states your target for 2015-16 and the previous year? I have a number here—

Mr Bowles: It is effectively a demand driven program. So while there will be targets built in over time, the reality is that if anyone comes along for that service, they can have it. It is demand driven.

Senator GRIFF: But you must be budgeting for a certain amount that you believe will redeem or use the service.

Mr Bowles: Yes.

Senator GRIFF: So what are you assuming that will be?

Mr Maskell-Knight: The estimates are essentially based on the current utilisation of it, Senator.

Senator GRIFF: Which is?

Mr Maskell-Knight: Around 30 per cent.

Senator GRIFF: And in numbers what would that represent?

Mr Maskell-Knight: There are three million children eligible from year to year and so broadly speaking one million children.

Senator GRIFF: The proposed expenditure—I appreciate that that is likely to change—for the 2016-17 year is stated to be \$326.7 million, which is up from \$312.6 million in 2015-16. Why is that?

Mr Maskell-Knight: Broadly speaking, that would be a slight increase in utilisation and an increase in average benefit expected. There is an estimates model that underlies this, so the variables are the number of children, expected utilisation rates and expected average benefits.

Senator GRIFF: But the scheme has been underutilised since its inception, so it just seems strange that you are assuming that it is going to be significantly more than what it is.

Mr Maskell-Knight: I do not think 'significantly more'. Can you read those two numbers again?

Senator GRIFF: It is about \$14 million more: \$326.7 million and for the prior year it was \$312.6 million.

Mr Maskell-Knight: Yes, so it is \$14 million on a basis of 300, which is about four per cent. So in that context it is not a significant amount.

Mr Bowles: Particularly when it is both what the average payment would be and the number of people. When you add the two together, it gets there pretty quickly.

Senator GRIFF: The report on the third review of the Dental Benefits Act 2008 found that the program was poorly promoted. Four of the 11 recommendations contained in the review related to better notification and promotion, such as making the letter more attractive, sending it as a hard copy and so on. Have you developed a plan? Are you planning to address all of these issues?

Mr Maskell-Knight: We have that under consideration, but these are decisions of government about providing greater promotion activities. As Mr Cormack said, the Department of Human Services write a letter annually to every family with a child eligible for the scheme. It is hard to imagine an approach that is more direct, really.

Senator DI NATALE: I have got some questions expressly on the Child Dental Benefits Schedule. Has the literature that was put out on your website, saying people would not be able to access the CDBS this year, been taken down?

Mr Cormack: We have updated the website a number of times this year. We updated it on the ninth to reflect the announcement by the minister the day before and that the benefits cap entitlement would be restored to \$1,000. We also provided some additional information around the national partnership agreements, which were also part of the measure.

Senator DI NATALE: Do you think now it was a mistake to have put up information that people would not be able to access the scheme, given that no legislation—

Mr Cormack: We have this exchange every time, so let us keep going.

Senator DI NATALE: Yes, and we will have it again today.

Mr Cormack: In essence—

Senator DI NATALE: You put up information that I said at the time was false and misleading because you were telling people they would not be able to access the scheme this year. As we now know that is exactly what has happened. Would you like to apologise for putting up false and misleading information?

Mr Cormack: We did not put up false and misleading information; we put up information that was based on government policy at the time at which it was put up.

Senator DI NATALE: It was not legislation—it was very clear that the legislation did not have the support of the parliament—and yet you put up that information at the time. Would you like to apologise to the people who were misled?

Mr Bowles: Senator, that is not going to happen in that way. We work off what is appropriate government policy, and that is exactly what we did in this case.

Senator DI NATALE: Are you writing to people to let them know that the measures in the omnibus bill will affect them given that that continues to be government policy?

Mr Bowles: What measures are we talking about?

Senator DI NATALE: Are any departments adopting the approach that you have to communicate with individuals that measures contained in that omnibus bill will apply to them?

Mr Bowles: I am not talking on behalf of other departments.

Senator DI NATALE: But if other departments adopted the approach that you are using that is, in fact, the effect of your logic?

Mr Bowles: I have no view on what other departments might do in that context. We update our website based on decisions that are made, and when they are remade we will make adjustments accordingly.

Senator DI NATALE: Is the government writing to businesses informing them that they will be receiving a tax cut?

Mr Bowles: Senator, you know that I cannot answer that.

Senator DI NATALE: But this is a really important point: before you communicate with individuals, shouldn't a measure be passed through the parliament before you actually provide them with information that is clearly incorrect, was incorrect at the time and has now been shown to be incorrect?

Mr Bowles: It was the position of the government of the day.

Senator DI NATALE: As is the government tax cut right now, and they are not communicating to business.

Senator Nash: Questions about tax cuts should be directed to the appropriate department, and you know that. You know that the secretary is not in a position to answer questions about tax cuts.

Senator DI NATALE: Is there any information now on any government website that promotes the scheme?

Mr Cormack: We have got material up on the website that explains the current arrangements as of 9 February, the day it was updated, and, as we discussed earlier, DHS, who are responsible for informing eligible recipients of this, are in the process of doing the letter distribution.

Senator DI NATALE: How does that work?

Mr Cormack: You would need to ask DHS exactly how they do that, but essentially we provide the policy advice and they are responsible for its communication to intended recipients. That is what has happened on this occasion. It is no different from any other arrangement we have with them. In summary, on our website and on the DHS website, there is up-to-date information about the scheme. It is the Department of Human Services that undertakes to write to eligible persons, and that process is underway.

Senator DI NATALE: Does that mean all eligible persons will now receive a letter indicating that they are eligible for the \$1,000 cap over two years?

Mr Cormack: Yes, that is right.

Mr Bowles: That has happened in the past. That has always been the case.

Senator DI NATALE: Yes, I am just confirming. Is there any other effort being made to inform people other than writing to them? Is there any other promotion of the scheme?

Mr Cormack: DHS are funded for the communication parts of this measure. We do not have a separate measure for a public communication campaign on this. The existing arrangements are that we outline the policy settings and the Department of Human Services communicates that directly to the intended recipients. That is what has happened.

Senator DI NATALE: Just to be clear on that: I imagine DHS acts on your advice with regard to promotion of the scheme? How would a decision like that be made? For example, would DHS independently say, 'We are going to run a \$10 million advertising campaign on the CDBS,' or would that be done in conjunction with you?

Mr Cormack: If there were to be a separate campaign, that would require another decision of government that has not been made.

Senator DI NATALE: Would you be involved in that process or would that happen—

Mr Cormack: Yes.

Senator DI NATALE: There is no other campaign, as far as you are aware, apart from writing to people?

Mr Cormack: Not at this point.

Senator DI NATALE: So the only way people will know about this is through getting a letter in the mail. Do they get that once? Every year? How does that happen? Is it just a one-off?

Mr Maskell-Knight: Eligibility is determined year by year. If your family is eligible for family tax benefit A or one of a number of other payments during the year, the child is eligible for the entire year. Human Services does not know until 1 January who those families are. As soon as the new year commences, they are able to do a mass mail-out to all the families they know are eligible at that time. As other families become eligible during the year, DHS writes to them as it occurs.

Senator DI NATALE: Does that mean every year there is—

Mr Maskell-Knight: Eligibility is a year-to-year proposition.

Senator DI NATALE: Somebody who is eligible through, for example, the entire course of their offspring's childhood would therefore get a letter every year?

Mr Maskell-Knight: Yes.

Senator DI NATALE: This is probably a question for DHS, but does that come with other information?

Mr Maskell-Knight: You are right. That would be a matter about which to ask the Department of Human Services.

Senator DI NATALE: It is not a stand-alone correspondence?

Mr Maskell-Knight: I do not know.

Senator DI NATALE: Given the department published information that was clearly inaccurate and that we have a report from the Australian National Audit Office and the department's own review saying that greater take-up would occur if there were better promotion, do you have any intention to promote the scheme in any other way? Is writing to people—and we do not know what form that takes, whether or not it is part of a whole lot of other correspondence they receive and ends up in the rubbish bin—to be the only way it is communicated?

Mr Cormack: We have policy authority to do what we are doing with this particular scheme, and that involves a direct annual communication to every eligible person.

Senator DI NATALE: We heard that, but I suppose what I am asking is—

Mr Cormack: We have no other plans at this stage to do that.

Senator DI NATALE: Given that you have used this justification in previous estimates hearings, justification for reducing cap or, indeed, abolishing the scheme altogether, the fact that it is under-utilised, do you think it would be now appropriate to improve the utilisation rate of the scheme to—

Mr Bowles: That is a matter for government.

Senator DI NATALE: Does the government believe it is appropriate to now look at how people are informed of this scheme to improve the utilisation rate?

Senator Nash: I think at this point, clearly, writing to every single eligible person is going to go a long way to ensuring—

Senator DI NATALE: But that is what has happened previously, and it has not had the impact that it needed to have, so I am asking the department—

Senator Nash: With the amount of focus that has gone onto this issue, outside of writing to families, at the moment, I think the government is confident that this is the way forward to

ensure that we get the information out there. As always, with all things, of course we will assess impact and those types of things, as with any kind of communication, but at this point this is the appropriate way forward.

Mr Cormack: The other point is, irrespective of the volume or nature of the communication, the reality is that there is a very high use of dental services, overall, by kids, whether it is through the CDBS, the state schemes, their own out-of-pocket expenditure or the government's health insurance arrangements, so there is already and always has been a very high level of access to dental services by Australian children. That is an important context point—

Senator DI NATALE: The oral health of young people in Australia is not commensurate with the level of wealth that Australia enjoys. In fact, when it comes to oral health, we do very poorly. But, that aside, if the Audit Office has said that there would be greater take-up with better promotion, is that something that the government would consider if utilisations rates do not increase, Senator Nash?

Senator Nash: Could you just repeat that for me.

Senator DI NATALE: Given that the Audit Office has said that greater take-up of the scheme would occur with better promotion—and letters have been the way that people have been informed of the scheme since its inception—if utilisation rates do not increase, is the government going to consider an alternative method of communicating it to eligible patients?

Senator Nash: That is a hypothetical if, and I am sure the minister will be considering that down the track if, indeed, that occurs. Currently, as you are now well aware, there will be contact with all of those who are entitled to this program, and that will indeed take place.

Senator DI NATALE: The government policy was to abolish the CDBS to establish a new—which I understand has changed—child and adult public dental scheme. Given the recent announcement around the CDBS, can you let me know what form the new child and adult public dental scheme will take.

Mr Cormack: There isn't one.

Senator DI NATALE: No, it was going to be established with the abolition of the CDBS. Mr Bowles, at one point, you said that it does not mean that it will not come back in another form at some point—I think that was at the previous estimates hearing. So I am just asking: are there any plans to proceed with the child and adult public dental scheme?

Mr Bowles: No.

Senator DI NATALE: Nothing—

Mr Bowles: Whatever I said at the last Senate estimates was in the context of information at that point in time but, if the decision has been made around the Child Dental Benefits Scheme, there is no further work happening on the child and adult public dental scheme.

Senator DI NATALE: Can I ask about the national partnership agreement. The 2013-14 budget promised \$391 million in 2016-17. It was reduced to \$155 million, and then down to \$107 million—slashed to less than a third of what was projected back in 2013-14. Are those figures accurate?

Mr Bowles: They sound reasonable.

Senator DI NATALE: We have heard from people including the Australian Healthcare and Hospitals Association estimate that the impact of that will be \$338,000 people losing access to public dental services. Can the department confirm those figures? Has it done any work to look at how many Australians would lose access to dental services?

Mr Bowles: No, we have not done those figures. Dental is a shared responsibility across the states, the Commonwealth and the private sector.

Senator DI NATALE: That is right. But you have reduced funding for dental by over a third, based on the last allocation in 2016-17.

Mr Bowles: The allocation is now \$107 million—I think as you indicated.

Senator DI NATALE: Reduced from \$391 million that was projected.

Mr Bowles: The last few years it has been around \$155 million—but, yes.

Senator DI NATALE: Do you think it is a problem when these sorts of agreement are struck at the 11th hour? I am just wondering whether you factor in the difficulty for many of the state organisations who often deliver these services—how they actually recruit staff, retention, and how they do any forward planning when these agreements are struck at a minute to midnight?

Mr Bowles: Clearly, we think about all of these issues when we are dealing with the states and territories. But, as I have indicated a number of times, the government of the day determines the policy position on all issues.

Senator DI NATALE: Do you think it would be appropriate—is it your view that, to allow state dental services to recruit and plan, having some certainty around funding is necessary?

Mr Bowles: It is not up to my view; it is what is government policy, and that is what I implement. If I have a view, I will express that to the minister of the day.

Senator DI NATALE: Senator Nash, when it comes to future agreements, does the government intend to repeat what it did this time around, which was, effectively, settle on a national partnership agreement with the states just before the existing partnership agreement expired? Or do you plan to give them a little more notice?

Senator Nash: I think, Senator, you would be aware that, not being the health minister, I cannot give you a direct answer on the specifics of that. I think it is fair to say, though, the government is always trying to do these types of arrangements in the most timely manner that we possibly can. Sometimes circumstances do not allow that to happen, but the intent is always to do them in the most timely manner.

Senator DI NATALE: Just to confirm the reduction in funding: the department has done no work to look at what impact that will have in terms of the number of people who will not be able to access to services?

Mr Cormack: We have two programs now. CDBS is an uncapped program. That is a demand-driven program.

Senator DI NATALE: For kids—yes.

Mr Cormack: We have a national partnership agreement of \$320 million over three years. Part of that has been the subject of agreements with the states—the first six months of this

financial year. For the balance of that, we are working through that with the states at the moment. Until we finalise those agreements with the states, we will not be able to give any specific or accurate advice about the amount of dental activity that is going to be delivered, because the agreements have not yet been struck.

Senator SINGH: Mr Bowles, with the NPA on adult public dental services, can you describe the types of adults that receive public dental services under the NPA?

Mr Bowles: Mr Cormack will do that.

Mr Cormack: Typically, they vary a bit across the states. But, typically, the state-based services are restricted programs, generally restricted to cardholders and their families. So they provide a range of—

Senator SINGH: Health care cardholders?

Mr Cormack: Typically, yes. There are some variations across the states, but the adult programs are means tested. Their offerings include an emergency service, an urgent care service and an ongoing restorative care service. Some of them have differing levels of access to more specialised dental services. So it is probably best described as a basic dental service. It is not the same as what people would access in the private sector. But it does vary a fair bit from state to state.

Senator SINGH: So it would predominantly be healthcare cardholders. You would agree that these are fairly vulnerable Australians.

Mr Cormack: They are low-income Australians.

Senator SINGH: So you would agree that these are fairly vulnerable Australians?

Mr Cormack: We are just describing the way the states—

Senator SINGH: I am asking: would you agree with that?

Mr Cormack: They are means tested. They are low income. They will include a mixture of vulnerable people. Not all people on low incomes are vulnerable. The best way to describe them is that they are all concession cardholders or family members of concession cardholders of one sort or another.

Senator SINGH: The government is committing \$320 million over three years to the MPA.

Mr Cormack: That is right.

Senator SINGH: Can you give us a breakdown by fiscal year.

Mr Cormack: For the first six months of the three-year period, which is from 1 July 2016, there is \$77.5 million available to the states. That is essentially half the amount that they got in the previous four years under the previous national partnership agreement.

Senator SINGH: But can you give it to me by fiscal year, not just the first six months of 2016-17.

Mr Cormack: It is \$104.5 million for 2016-17, \$107.8 million to 2017-18 and \$107.8 million to 2018-19. The reason why I mentioned the first six-month period is that there was a commitment given while the new scheme was being worked out to effectively extend the previous arrangements, which were \$155 million per year, for the first six months. The first year is a bit different in that sense because they are effectively getting half the amount they

would have got under the previous agreement. Then the rest is flowed over the 2.5-year period. We will need to work through the details of that with the states. But those three figures I have given you are the amounts allocated for each fiscal year.

Senator SINGH: With 50 per cent less for that first year?

Mr Cormack: It is not actually 50 per cent—

Senator SINGH: You said half the amount.

Mr Cormack: Yes, half the amount of the previous year—

Senator SINGH: Isn't that the same as 50 per cent?

Mr Maskell-Knight: It is half the amount that was paid in 2015-16, plus another \$27 million.

Senator SINGH: The 2012-13 MYEFO showed that Labor had budgeted \$391 million a year for the NPA. So the government is really cutting around \$300 million a year. What is your estimate of how many fewer patients will receive services per year as a result of this massive cut?

Mr Cormack: I do not think we can give that estimate.

Senator SINGH: You do not know how many people this cut is hurting?

Mr Bowles: We gave that answer to Senator Di Natale for—

Senator SINGH: Well, I am asking for it.

Mr Bowles: We do not have one. We do not have that. This is something that is shared between the states and the Commonwealth to start with.

Senator SINGH: You do not have an answer to that? You do not know how many people this cut is hurting?

Mr Bowles: I have said it three times now.

Senator SINGH: Okay. Let me help. Your website says that \$155 million in 2015-16 funded services for 178,000 patients. Using that same ratio, a cut of \$294 million a year means 337,000 patients a year will miss out. Does that sound right to you?

Mr Cormack: No, it does not because it assumes that the agreement has the same terms and conditions as the previous agreement. It also assumes that the amount, if you like, per weighted activity unit is the same. We have to work those things through with the state and territory governments. We are not sure what else they are bringing to the table. These are matters that we are working through with the states and territories at the moment. Until we do that, as the secretary said, we cannot give you an answer of how many activity units will be actually funded.

Senator SINGH: Sorry, I thought I was using your maths. Can you take on notice, when you do your work with the states and territories, to provide this committee with the number of people that will be suffering?

Mr Bowles: We can take it on notice, but we will not be able to answer the majority of your question because the states actually run the schemes.

Mr Cormack: They do most of the work. They do the work and provide most of the funds for state services. We make a contribution.

Senator SINGH: Are you able to take it on notice?

Mr Bowles: I have said we will take it on notice. I am just qualifying that I may not be able to give you exactly what you ask because the states actually run the dental services.

Senator SINGH: I just want to quickly ask about the diabetes election commitment for continuous glucose monitoring, and particularly the delay. I wanted to just go back and ask if that delay is because you have underestimated the demand for CGM?

Mr Bowles: No, Senator. We are out of sync again; I had people who could talk about that here earlier on. But the answer is no. We are getting confused about budget documents versus policy documents and all that sort of stuff.

CHAIR: I think Senator Dastyari covered this earlier.

Mr Bowles: He did.

Senator SINGH: It was just a follow-up on that. Also, is it uncapped? Can as many people as they want receive it?

Mr Bowles: I will have to take that on notice.

Senator SINGH: Can you take it on notice?

Mr Bowles: I will take it on notice, yes.

Senator SINGH: How will CGMs be allocated?

Mr Bowles: I will take that on notice. We talked about that earlier and those people have gone.

Senator SINGH: I know. It is just that those questions were asked and I have some follow-ups.

CHAIR: On the basis that officers are not here, it makes it difficult to provide actual answers.

Senator WATT: These are what I suspect will be the last questions from the opposition on outcome 4. Mr Bowles, they are about Medicare and bulk billing in particular, so it is a fairly general thing under this outcome. With respect to the bulk billing rate, my understanding is that it is reported for all non-referred attendances. I understand the percentage of people who are bulk billed for non-referred attendances is reported by the department.

Mr Bowles: I will get Mr Stuart to come to the table. We are talking about services, not people.

Senator WATT: Yes, that is right. So if I go five times it counts as five and not one, is that right?

Mr Bowles: It is services, yes.

Mr Stuart: The department has a long-standing publication series on bulk billing, which includes all non-referred attendances as a proxy for general practice. It has been publishing the data like that since about 1984.

Senator WATT: How often is that published?

Mr Stuart: We publish quarterly.

Senator WATT: What is the most recent quarter that has been published?

Mr Stuart: We published the December quarter data a few days ago.

Senator WATT: So we would be expecting to get the March quarter data in about April or May?

Mr Stuart: Yes.

Senator WATT: Is that data broken down by electorate?

Mr Stuart: We do not generally publish electorate-level data.

Senator WATT: But it would be possible to publish that on an electorate basis, wouldn't it?

Mr Stuart: In principle.

Mr Bowles: It would be a lot of work, though.

Mr Stuart: We do not generally produce or publish that information.

Senator WATT: I understand that might not be what you do. There are many departments that can publish data on an electorate basis, so there would be no reason—

Mr Bowles: I think we would have to have a look, Senator. I am just flagging that it is a lot of work because there are 385 million services. It is hard work.

Senator WATT: Could you take that on notice, please?

Mr Bowles: Yes.

Senator WATT: I would probably be satisfied with that most recent data from the December quarter. What data does the department have on average out-of-pocket costs per GP visit?

Mr Stuart: That was also published a few days ago. For GPs, for the July to December period, for non-referred GP attendances the average out-of-pocket cost was \$33.45. That is the average for the about 15 per cent of people who pay an out-of-pocket cost, because the bulk-billing rate is 85.4 per cent.

Mr Bowles: It is not the average over the entire community.

Mr Stuart: I should correct that amount: it is \$34.24.

Mr Bowles: I think the critical piece is that it is the average for those who pay; it is not the average over everybody.

Senator WATT: You are saying that about 85 per cent of services nationally are fully bulk-billed, if you like?

Mr Bowles: 85.4 per cent of GP services.

Senator WATT: For the remaining 15 per cent or thereabouts, the average out-of-pocket per service is \$33?

Mr Stuart: \$34.24.

Senator DI NATALE: How does that compare to previous years? Do you mind if we ask that?

Senator WATT: You read my mind.

Mr Stuart: The previous year-to-date figure from July to December, 2015-16—the matching six months of the previous year—was \$32.76.

Senator WATT: Was that figure of \$34.24 just for the December quarter?

Mr Stuart: That was for the period July to December, 2016-17.

Senator WATT: So a \$2 increase, essentially, over 12 months?

Mr Stuart: It is not \$2.

Senator WATT: Just short of \$2?

Mr Stuart: It looks like about \$1.50 to me.

Senator WATT: Sorry, you are right. I have already asked for some of that information to be broken down on an electorate basis. Do you have data on a state-by-state basis?

Mr Stuart: We do, and that is regularly published.

Senator WATT: Has that been published in this most recent data?

Mr Stuart: Yes.

Senator WATT: What is the state with the highest rate of bulk-billing?

Mr Stuart: Are we talking about for GPs?

Senator WATT: I am talking specifically about item 23A, I think, which is non-referred attendances.

Mr Stuart: I do not have that. Item 23 is the so-called level B consult, and it is only one of the items that form part of the GP set.

Senator WATT: Is that 85.4 per cent figure beyond item 23A?

Mr Stuart: Yes, it includes a range of items claimed by GPs.

Senator WATT: On that measure, what is the state with the highest?

Mr Stuart: I only have total Medicare bulk-billing, not GP-only bulk-billing by state in front of me.

Senator WATT: Has all of that data you are reading from just been published?

Mr Stuart: Yes.

Senator WATT: On a state-by-state basis?

Mr Stuart: That is right.

Senator WATT: Can the average out-of-pocket costs that we have talked about, which are currently at \$34.24 for that cohort, be provided on an electorate basis as well, if that work has been done? Would you take that on notice, please?

Mr Stuart: Yes.

Senator WATT: Is that data already reported or available on a state-by-state basis, if not by electorate?

Mr Stuart: Not for GPs only. It is not regularly published.

Mr Bowles: We will take it on notice, because we will have to see if we have to manufacture something.

Senator WATT: At a minimum I would be keen for state-by-state; ideally, electorate.

Mr Bowles: For GP non-referred?

Senator WATT: Yes. Does the department know how many visits on average are bulk-billed?

Mr Stuart: Yes.

Senator WATT: What is the answer to that?

Mr Stuart: 85.4 per cent of visits are bulk-billed.

Senator WATT: Can you convert that into a number?

Mr Bowles: If we work on roughly 385 million services—

Senator DI NATALE: That is services, not visits.

Mr Bowles: Services equate to visits; they just do not equate to people.

Senator DI NATALE: No, because you might bulk-bill one service but charge a fee for another service.

Mr Stuart: You might, but I think it is a pretty close statistic. I think that most visits to the GP result in one service.

Senator DI NATALE: So you reckon it is a pretty close proxy for visits?

Mr Stuart: I think so.

Mr Bowles: It is close; it would not be perfect.

Senator WATT: The reason I am asking is: we know pretty reliably that older Australians tend to visit their GP much more often than younger patients. So if, for argument's sake, the average per Australian is six visits per year, does the department know how many of these visits are bulk-billed on average? Again, would it be the 85 per cent, roughly?

Mr Stuart: Older people are bulk-billed considerably more than the average. I do have a bit of that information here with me; just bear with me—

Senator WATT: Again, that information you are about to give us—is that published or not?

Mr Stuart: No.

Senator WATT: In that case, I would love to hear it.

Mr Stuart: This is data for last financial year, 2015-16, when the overall bulk-billing rate was 85.1 per cent, the bulk billing rate for concessional patients was 93.8 per cent, and 88 per cent for children.

Mr Bowles: That is not a complete proxy for what you asked, but it is probably the closest we can get to with the data.

Senator WATT: What I am trying to do, I suppose, is to convert that to a number of visits or number of services per person per year—

Mr Bowles: It is very difficult because not every person visits a doctor every year and some people visit multiple times every year. So it is not a simple equation to actually get to where you want to go.

Mr Stuart: We did answer a question of that kind on notice from the last hearing, which goes to: what proportion of patients get bulk-billed all the time, some of the time and never? I can tell you that, in line with the trend for increased bulk-billing, all of those indicators are going in the same direction—that is, the proportion bulk-billed all the time is going up, bulk-

billed some of the time is going up and bulk-billed never has fallen from about 20 per cent to about 10 per cent in the last decade. That is from memory, but it is on the record from the last hearing.

Senator WATT: It might make sense if I ask for an update of those figures as a question on notice arising from this hearing as well. You would be aware that the college of GPs, among others, are of the view that the way the bulk-billing rate is reported is artificially high. Are you aware of any evidence of GPs limiting the amount of time they are spending with patients, or asking patients to come and see them for another appointment due to time constraints?

Mr Bowles: I cannot speak specifically to that, but we went through a whole series of these at the last estimates hearings about differences of views, and we get back to: services versus people versus a whole range of issues.

Mr Stuart: We do not accept that the rate is artificially high. It is a rate that has been consistently measured in the same way since 1984, and consistently published, and it is based on every service obtained by every Australian who goes to the doctor.

Senator WATT: I understand that, but have any representations been made that you are aware of, whether it be by peak bodies, GPs or elected representatives on behalf of their constituents, that suggest that GPs are limiting the amount of time they are spending with patients?

Mr Stuart: This is a longstanding debate in the health system about the amount of time that GPs spend with patients, and it is multifactorial. The government has a policy on Health Care Homes which is intended to enable longer time to be spent with patients with chronic disease. There is a long history of debate in this area.

Mr Bowles: But equally there are items for longer consults as well. There are short consults: 20 minute—23 you talked about—and then there are longer consults. So GPs can use those different consults, depending on what they are actually treating in a patient, and we see evidence of all of that.

Senator WATT: As to the concessional breakdown that you just provided to me—as in: older people, younger people, that kind of thing—did you say that that has been published for the most recent quarter?

Mr Stuart: No. I was referring to some analysis that I have in front of me, but it is not regularly published.

Senator WATT: And you have taken that on notice. In fact, if you have got that data there, would you be able to table that to the committee?

Mr Bowles: We will take it on notice. It is in the context of a whole range of other things. So we will take it on notice and provide you with—

Senator WATT: I just do not want to have to wait three, six or nine months for something that is right there.

Mr Bowles: We are pretty good at getting our questions on notice back.

Senator WATT: You are certainly better than Senator Brandis—I will give you that!

Mr Stuart: I will put those numbers—

Mr Bowles: The numbers are in the *Hansard* too if you want to—

Senator WATT: Yes. I will leave it at that. Thank you.

Senator DI NATALE: I think you said 85 per cent was the current bulk-billing rate for services—

Mr Stuart: It is 85.4 per cent for GPs.

Senator DI NATALE: How does that compare to the previous six months?

Mr Bowles: It was 84.7 per cent, from memory.

Mr Stuart: Yes, 84.7 per cent. It has gone up compared to the same period in the previous year.

Senator DI NATALE: Thanks.

[15:00]

CHAIR: Thank you very much. That brings us the end of outcome 4. We will now move on to outcome 2, starting with program 2.1, mental health.

Senator O'NEILL: In February the new minister announced an additional four suicide prevention trial sites. For the record, because there seems to be some confusion around this, could I ask the department to clarify how many suicide prevention trial sites there actually are?

Ms Cole: There are 12 in total.

Senator O'NEILL: Including the additional four or with—

Ms Cole: Yes.

Senator O'NEILL: So there are 12 sites? Could you give me the precise locations of each of those, please.

Ms Cole: They are basically indicated by location by PHN. The relevant PHNs are Perth South—

Senator SIEWERT: Sorry, I am having trouble hearing you.

Senator O'NEILL: Can you restate what you said there at the beginning? You said that the suicide prevention trial sites are co-located—

Ms Cole: The sites are usually a geographical location within a PHN, but we describe them in terms of the PHNs, if you follow what I mean.

Senator O'NEILL: I might need to get two pieces of information. Can you firstly give me the PHNs?

Ms Cole: The PHNs are Perth South, Brisbane North, North Coast New South Wales, North Western Melbourne, Townsville, Country WA—and actually there are two for Country WA, and I will clarify the locations, as that is a very large PHN, in a moment—Tasmania, regional South Australia, Darwin or Northern Territory PHN—

Senator O'NEILL: So that was called the Northern Territory PHN?

Ms Cole: Yes.

Senator O'NEILL: What is number 11?

Ms Cole: Western New South Wales PHN. The last one—noting that there are two in Country WA—is Central Queensland, Wide Bay, Central Coast PHN. In terms of locations more specifically within those PHNs, Perth South is basically the Mandurah region. Brisbane North is just Brisbane North—it is a fairly contained geographical region. North Coast New South Wales is, again, the whole of that region. North Western Melbourne is, essentially, North Western Melbourne. Northern Queensland is centred around the Townsville region. Country WA has two—one is focused in the Kimberley region and one is focused in the Mid West region. Tasmania has not been determined yet, but we believe it will be largely in the north-west region at this stage. The regional South Australia one, we think, will be around Whyalla, that kind of region, but it has not yet been finally determined. Northern Territory is Darwin. With Western New South Wales we are thinking it will be the north-west New South Wales region, but it has not yet been completely determined. And we think it will be Central Queensland and Wide Bay, those two regions, rather than the Sunshine Coast region within that PHN.

Senator O'NEILL: Just to be clear: the last one is the Central Queensland and Wide Bay area but it is going to be located at?

Ms Cole: Largely in those two broad regions, rather than the Sunshine Coast element of that PHN.

Senator O'NEILL: So upper rather than the southern end?

Ms Cole: That is correct.

Senator O'NEILL: You spoke of some of these locations with a little more confidence than others. When you talked about Perth South you said Mandurah. Is it any particular spot in Mandurah that this is going to be located in?

Ms Cole: No. They are meant to be regional trials. The Mandurah region was chosen mostly because it has a high incidence of youth suicide—it has had a cluster in that area—and the trial has a focus on the youth suicide issue. That particular trial has a focus on youth suicide.

Senator SIEWERT: Just the one in Mandurah?

Senator O'NEILL: I am going to go through each one of them and ask you for some detail. Brisbane North is the Brisbane North region you said coincides with the PHN descriptor?

Ms Cole: That is correct.

Senator O'NEILL: Whereabouts, and what is it focusing on?

Ms Cole: It does not have a particular focus, that one; it is just a suicide prevention trial. Brisbane North PHN are also doing some work around severe mental health illness, so I expect they will link those two issues, but it has not been specified.

Senator O'NEILL: So, it has not been specified but you believe it will have a focus on severe mental health illness?

Ms Cole: In the sense that the work flows together quite nicely, and I believe they will bring those two elements together as they proceed.

Senator O'NEILL: Okay. North Coast New South Wales?

Ms Cole: North Coast New South Wales, that particular PHN, has a higher than average five-year suicide rate, so that is why that region was chosen.

Senator O'NEILL: And just so that I can be clear: where are the boundaries of North Coast New South Wales? It starts at the border?

Ms Cole: Yes. It goes south from the Queensland border to just above Newcastle.

Senator O'NEILL: North Western Melbourne?

Ms Cole: North Western Melbourne is pretty much as described: north-west Melbourne. Again, that is a—

Senator O'NEILL: The focus?

Ms Cole: The focus on that one is the broader suicide issues, because there is a relatively high rate in that region as well over the five-year statistics.

Senator O'NEILL: Does that differ in any way from North Coast New South Wales?

Ms Cole: No.

Senator O'NEILL: So those two are just broader suicide issues?

Ms Cole: That is correct.

Senator O'NEILL: And the only differentiation we have seen so far in the four that we have discussed is that Brisbane North is severe mental health illness?

Ms Cole: Yes. Brisbane North have a separate trial they are running around severe mental health, and I believe they will run those two things together.

Senator O'NEILL: And Mandurah is different because it has the high youth suicide?

Ms Cole: That is correct.

Senator O'NEILL: So then we go to North Queensland, centred around Townsville.

Ms Cole: Yes. That is the one which has a particular focus around veterans' issues.

Senator O'NEILL: Country WA?

Ms Cole: Country WA has two. There are two trials which are identified as specifically focusing on Indigenous suicide issues. One of those is the Kimberley region and the other one is the Darwin region, the Northern Territory one.

Senator O'NEILL: And Country WA Mid-West?

Ms Cole: Country WA Mid-West is around the high rate in that area, but it is expected that it will also have quite a strong focus on the Indigenous population and the suicides in that population.

Senator O'NEILL: For clarification for me: for the Kimberley region and Darwin it is exclusively focused on Indigenous suicide, or is it general suicide plus focus on Indigenous?

Ms Cole: When you are doing a community intervention, it should be beneficial for the community as a whole. However, there is a particular emphasis around particularly vulnerable subpopulations within those regions. I think that may answer your question.

Senator O'NEILL: Tasmania: you were a little more uncertain about where this one was going to be located, but you indicated probably the north-west, which I am sure Senator Polley would be interested in hearing about.

Ms Cole: This one has not formed its community advisory group yet, so there is a little bit of room to move in terms of its actual location. But the statistics would suggest a concentration around the north-west Tasmanian region as being a higher priority area.

Senator O'NEILL: Any particular focus?

Ms Cole: No, not in that one.

Senator O'NEILL: You just mentioned a community advisory group. With the ones that we have discussed—Brisbane, Perth, North Coast New South Wales, north-west Melbourne, Northern Queensland and country WA—were the decisions to have the series of foci that you have indicated from community advisory groups, or was it from another source that that was determined?

Ms Cole: The decision around the trial sites was informed by where the high-priority populations are in terms of the high-vulnerability populations. The decision to have two Indigenous trials was specified in the government's election commitment on expanding the number of suicide trials.

Senator O'NEILL: I will have more detailed questioning on that, but let us just keep going to the bottom of the list here. Regional South Australia: uncertain, but you were indicating Whyalla?

Ms Cole: Around that region. I think it will be much broader than Whyalla, but we certainly think that sort of peninsula-type region at this stage.

Senator O'NEILL: No particular focus there?

Ms Cole: No. The issues around rural Australia, in terms of suicide, are fairly well known. There is a general emphasis in these trials on the locations chosen because of that issue around the higher rates in regional and rural communities.

Senator O'NEILL: Darwin: Indigenous suicide focus, and that is set?

Ms Cole: Yes.

Senator O'NEILL: North-west New South Wales: you are unsure about that?

Ms Cole: It is going to be western New South Wales. At this stage, the indications are that it will be concentrating largely in the north-west of that region. Again, that is around small rural communities and remote communities, which tend to have a higher rate of suicide than other communities when you look at them over a long-term period.

Senator O'NEILL: Central Queensland: is that Wide Bay, the upper region, rather than the Sunshine Coast?

Ms Cole: That is correct. Because, again, when you look at that region and break it down, the highest suicide rates are in those two areas rather than in the Sunshine Coast area particularly.

Senator O'NEILL: Is there any particular focus?

Ms Cole: No.

Senator O'NEILL: Just rural and regional suicide?

Ms Cole: Yes, that is right. It is essentially trying to look at where there are high areas, where there is considerable benefit in running a trial, in terms of actually having a measurable

effect, hopefully, on the suicide rates in those communities and what learnings can then be moved to other communities within Australia that have similar issues.

Senator O'NEILL: Can I ask you then about your evaluation and assessment processes to establish where these suicide prevention trial sites were determined or are in the process of being determined to be? The methodology for selection, I guess.

Ms Cole: Essentially, some of the sites were determined in the election commitment. There were four that were already in place.

Senator O'NEILL: Could you name those for me?

Ms Cole: The ones that were already specified were Perth South, Brisbane North, North Coast New South Wales and North Western Melbourne, and then the election commitment also specified Tasmania and regional South Australia.

Senator O'NEILL: So they were election commitments. Were they based on any advice from the department?

Ms Cole: There were four that were already decided by the government prior to the election—the top four that I just mentioned. And then—

Senator O'NEILL: Did the department give the government any advice to inform that decision making?

Ms Cole: Yes.

Senator O'NEILL: So, Perth South, Brisbane North, north coast district and North West Melbourne?

Ms Cole: That is correct.

Senator O'NEILL: You advised the government that these were four sites that should have a suicide prevention trial?

Ms Cole: That is correct. Those were decided—

Senator O'NEILL: And when did you advise the government of that?

Ms Cole: These were pre-election. In the government's response to the Mental Health Commission's report they made some commitments around a number of lead site trials which would have a number of focuses. One of those focuses was around suicide prevention. We advised the government that these four regions would be good regions in which to hold those trials.

Senator O'NEILL: And that was based on what data?

Ms Cole: That was based on a combination of the suicide data over a five-year period—the most recent aggregated data that we can get in a region. We do not tend to look at one-year data for suicide by regions, because it is too small and it has too much variation. So we look at it over a five-year period.

It was also based on a bidding process by the PHNs, where they were bidding for the lead sites. They were nominating which areas they believed from their needs assessments that they should be working in.

Senator O'NEILL: Was that coordinated in any way? That was just individual PHNs—

Ms Cole: That is correct.

Senator O'NEILL: Some people may just have been quick off the mark to get their bid in?

Ms Cole: They all had an opportunity to put in a bid, and then there was a process of selecting and checking within the department, and then a recommendation to government.

Senator O'NEILL: And did all PHNs put in a bid?

Ms Cole: I cannot answer that off the top of my head. I will have to take that on notice.

Senator O'NEILL: If you could, that would be of interest. If they all did, or who did and who did not; some detail around that would be good.

Ms Cole: Yes. I think that at least the vast majority of them did, but I need to double check that record.

Senator O'NEILL: Okay. Then you mentioned Tasmania and regional South Australia—

Ms Cole: They were specified in the election commitment.

Senator O'NEILL: They were not ones that were recommended by you, though?

Ms Cole: They were specified in the election commitment, and it was a—

Senator O'NEILL: Did you provide only four recommended sites to the government prior to the election? Or did you nominate more sites?

Ms Cole: Actually, it is a some time ago now and I cannot remember off the top of my head what the actual recommendations were. I think we are getting into that area of advice to government anyway, so I will get back to you on notice.

Senator O'NEILL: Could you take on notice how many PHNs sought to participate—

Ms Cole: Yes.

Senator O'NEILL: how many you recommended would be appropriate and how many you recommended to the government?

Ms Cole: There were always going to be 10 sites. There was a question about the mix, content and focus of those lead sites.

Senator O'NEILL: Who chose the number 10?

Ms Cole: It was in the government's response to the Mental Health Commission's report.

Senator O'NEILL: And was that based on anything? Or was it just a number pulled out of the air?

Mr Bowles: I think that the Mental Health Commission—

Senator O'NEILL: Recommended 10?

Mr Bowles: No—well, I think we would have to take on notice the number, based on the Mental Health Commission's report. It recommended that we run a number of these trials.

Senator O'NEILL: Yes, but it is the number 10 that I am trying to figure out—

Mr Cormack: There is just an intervening step here. Clearly, there was the National Mental Health Commission's report. The government considered that in great detail. It also had an expert reference group that was established to help inform the government's response. The government's response was released and it included the translation of what it had deduced from the National Mental Health Commission's report and the advice of the expert reference

group, and that was released in November 2015 as the overall response. That included some of the measures that Ms Cole has just outlined.

Senator O'NEILL: Okay. Could I go to Tasmania and regional South Australia? Do you know why they were selected at No. 5 and No. 6?

Ms Cole: It was in the election commitment of the government. I cannot speculate as to what was in the mind of the government at a particular point in time; however, when you look at the statistics there is clear justification for those two locations.

Senator O'NEILL: And the remainder? There are six. We have got 12. Ten was what was recommended. We have got an extra two then.

Ms Cole: The election commitment specified that there would be 12, noting that we already had four in train. It then specified two more sites and also specified that two would be focused on Indigenous suicide issues.

Senator O'NEILL: Where did the minister's announcement of an additional four suicide prevention trial sites come from then in February?

Ms Cole: We provided advice as to where those sites could be and the minister at the time made the decision as to where those final locations would be.

Senator O'NEILL: So they were not additional; it was just naming four to bring it up to 12?

Ms Cole: That is correct.

Senator O'NEILL: So they were not additional?

Ms Cole: That is correct.

Senator O'NEILL: They were simply being nominated at that point in time?

Ms Cole: As the 12 that were specified in the election commitment.

Senator O'NEILL: Thank you for clarifying that. So the decision to have the suicide prevention trial sites was based on specific demographic data? Is that how you would describe it?

Ms Cole: We provided demographic data. We also looked at capability in terms of the communities concerned. Although an area can have notionally a very high suicide rate, because it is done on deaths per 100,000, if that community is very small it is probably not able to sustain a suicide prevention trial in and of itself. So there were two factors considered there. The third factor that was considered is there is a fair bit of activity on this issue by state governments and non-profit organisations as well, particularly the Black Dog Institute in New South Wales, who are running four trials in that state. We did not obviously recommend that there be overlapping trials by a state government and a Commonwealth government or by a non-profit organisation—in this case, the Black Dog Institute—and the Commonwealth.

Senator O'NEILL: So there were multiple factors involved in those decisions—population, demographic, capability of the region and activity by state—that precluded people. If central Sydney put in a bid, because the Brain and Mind Centre is there and there is already activity in that area they were unlikely to get anything from these trials; is that correct?

Ms Cole: If there was already an active suicide prevention trial, as in the case in New South Wales and Victoria, we avoided the same regions essentially.

Senator O'NEILL: So we have discerned the four that you recommended to the government, there were two that emerged in the course of the election and there are the remainder.

Ms Cole: Yes, noting that there was a specification that two had to have an Indigenous focus.

Senator O'NEILL: So that accounts for the Northern Territory and the north-west of Western Australia?

Ms Cole: The Kimberley. The two specific ones.

Senator O'NEILL: Okay. What about the remainder? How were they selected? Did you make a recommendation? Did the department make a recommendation to the minister or did the minister tell you which ones were going to be—

Ms Cole: The minister asked for our advice and we provided that advice around possible sites.

Senator O'NEILL: So the minister has made the announcement. Does the ministerial announcement match your advice?

Mr Bowles: I expect that is a bit unfair. We provide advice to ministers. We do not make final policy decisions. That is not saying one thing or the other. I am just saying—because I do not know the answer—

Senator O'NEILL: I put a box in that question. The interaction between the department and the minister remains a secret. We do not know exactly what happened there?

Mr Bowles: No. That is advice to ministers, as has ever been thus and I have worked for both sides of government.

Senator O'NEILL: There is a lot of interest in this area and, as you have indicated, the majority of PHNs put in a bid. You can understand why a lot of people are saying, 'Why didn't we get it?'

Mr Bowles: That happens on just about everything we do when we come out with trial sites—trust me. If you are only going to run 10 or 12 something-or-others and there are 31 of them, you are always going to have at least 21 or 19 that are going to be unhappy. So that is the life of us having to manage these dynamics, and it has always been the same.

Mr Cormack: Just to add to what the secretary said, this was in the context of implementing a very large broadscale package of mental health reforms that were announced in 2015. Suicide prevention was a very key aspect of that reform package, which was a response to the National Mental Health Commission's report. At the same time there were trial sites for other areas of the overall reform package as well. We have to take that into account as well. We were essentially looking to focus on early implementation in a number of sites—there were really nine key areas of reform that were announced in 2015.

Senator O'NEILL: I have questions about that later too if we get to them. Thank you. Could I ask if the department has come to any decision about how it will measure the outcomes of the suicide prevention trial sites? Is there established criteria?

Ms Cole: We are in the process of seeking a provider to do the evaluation for us in this area.

Senator O'NEILL: Will they determine the criteria of assessment or have you already determined the criteria of assessment?

Mr Cormack: It is an iterative process. The government has committed \$3 million to support an evaluation of this. Indeed, any measure of this importance and this size is subject to a formal process of evaluation. As Ms Cole said, we will approach the market, we will get on board an evaluator, we will sit down with the evaluation team, we will go back to the measure and the policy objectives, and we will structure an evaluation around that. So it is an iterative process. We have not determined that as yet. We will have that sorted once we get the team on board that will be undertaking that. At this stage we have not got them on board, but there is funding set aside to do that.

Senator O'NEILL: When you said, 'We will go back to the measure and the outcomes,' what sort of measure are you referring to?

Mr Cormack: We are going back to what we were seeking to achieve in the suicide prevention pilots. The initial four subsequently increased to 12.

Senator O'NEILL: Can you articulate those outcomes for me?

Mr Cormack: I might ask Ms Cole to go into the detail of the data, but essentially these are new measures, and, when we go out to seek an evaluation team, we will work with the evaluation team to make sure we are able to assess the impact and to structure the evaluation around the goals and objectives of each of these trials. That is work we will be doing when we get them on board.

Ms Cole: Essentially we do have a bit of a difficulty around the data lag and also numbers in terms of measuring effectiveness of suicide prevention. We will probably look at a proxy measure—

Senator O'NEILL: Sorry, I am having trouble hearing you. Could you start again.

Ms Cole: Because of the data lag that is inherent in suicide data, we will probably have to use a proxy measure as our major measure, and that proxy would be suicide attempts, because we can get that much faster through the hospital system and police data and so forth rather than the finalised suicide numbers for each region. The other thing we will be looking at is the effectiveness of individual measures that are chosen to be taken in each trial in consultation with the community advisory group. For example, what we will be looking at is, in a sense, things that the community are suggesting in a systems based approach to suicide prevention. There are a number of theoretical underpinnings now for systems based community responses on suicide prevention and which of those are effective in which circumstances. A lot of the trials are thinking about issues such as family training, mental first aid for family members—those sorts of measures where you are trying to create that level of protection across a vulnerable community as much as possible. So that is the kind of thing that we will be looking to test as much as possible in these trials in terms of effectiveness and their applicability to the wider community going forward.

Senator O'NEILL: You referred to the community advisory group. Is that the community advisory group that is aligned to the PHN or is it a specific community advisory group aligned to the suicide prevention initiative?

Ms Cole: It is the latter.

Senator O'NEILL: So it is a special select group. Who selected it? How is it being informed? What is its structure? How transparent are its deliberations?

Ms Cole: It varies from trial to trial depending on the circumstances and the region. Probably the best established one is the Kimberley region one, which has now had two formal meetings. Essentially, it has a combination of community representatives from the major communities in the Kimberley region.

Senator O'NEILL: Can you give me an example of who that is?

Ms Cole: For example, there might be a representative from the Derby community, the Halls Creek community and so forth across the region.

Senator O'NEILL: When you say 'community', do you mean the Indigenous community in particular or the broader community?

Ms Cole: I mean the Indigenous community. Then it has that major service providers. It has a representative from relevant government departments and the state health department. It has representation, I believe, from the WA Police and it has the education department on it. I can give you a list on notice if you would like, but that gives you a sense of the number of people involved, interested and engaged in the issue.

Senator SIEWERT: You are going exactly where I was going to go first. You offered to give us a list for the Kimberley. Can you give us the list of who is on it? The complete list would be very much appreciated.

Senator O'NEILL: And for all those PHNs, wherever you have it, would be really good.

Senator SIEWERT: For all of them, yes. Is there additional funding going into the Kimberley beyond the trial for suicide prevention?

Ms Cole: Yes, there is.

Senator SIEWERT: Can you articulate what additional funding is going in? With the different announcements that have been made, I am confused about what is new money and what is the same initiative being re-announced in a different way.

Ms Cole: I will take that on notice. The figures that I have before me are aggregated up country WA PHN, so I will need to go back to the PHN and asked them about their allocation for the Kimberley region.

Senator SIEWERT: I want all the allocations for the Kimberley so that I am clear about what is existing funding and what is new funding and, given that we only have one PHN, perhaps you could do it for the rest of the regions that you have articulated getting funding from other areas. Thank you.

Senator SMITH: On the Kimberley, was the Bishop of Broome consulted? Did officials engage with him at all? He has been around the community for a very, very long time. I met with him after some of the earlier discussions and was surprised to learn that he had not been approached. He has a lot of experience unfortunately around these suicide issues. On notice, could you let me know if he was involved and if he was not why that was the case?

Ms Cole: Actually, I can answer that question for you. He was invited to the first meeting and was not able to attend.

Senator SMITH: But he is being engaged? Is he on the group?

Ms Cole: No, he is not. Obviously, if Minister Wyatt wished to engage with the bishop that would still be an option available.

Senator SIEWERT: In the first instance, I want to follow up a question on notice—question 521—but I do not think you actually need that for my next lot of questions. We did engage in a discussion last time around the PHNs identifying gaps in the provision of mental health services, and you did answer by saying that they have gone up on the website. I note as an aside that at least one of the PHNs, in fact, did not have the information up on the website on the date that it was said that all of them did have it up. Have you done a summary of what major issues have been identified across the 31 PHNs regarding the key gaps in mental health services?

Ms Cole: We have not got an aggregated document along those lines, but we could, if you wish, take on notice a summary for you against the 31 needs assessments.

Senator SIEWERT: Why have you not done that? I would have thought it was a fairly obvious thing that the government would want to know, given the concerns about the gaps in funding, given the various changes, given the shift to NDIS.

Mr Cormack: We asked each of the PHNs to undertake a needs analysis right across the full areas of programs that they are responsible for. Mental health is a very important part of their work, but they have got other activities as well. They submit their needs assessments, and those are then compiled into their commissioning plans. They are meant to be an autonomous, locally responsive entity that is able to align needs with a more flexible funding pool. We certainly do collect all that information that they submit to us and, as Ms Cole said, we will certainly make available whatever information has been provided to us, but we do not have that at hand at the moment in a single, consolidated document for every single PHN and every single program area, because they are meant to undertake this. That is their mission. We contract them to undertake the needs assessment and we also provide them with flexible funding to be able to meet those needs, and most of them are well advanced in the process of commissioning services to fill those gaps.

Senator SIEWERT: Let me get this straight: you have done no analysis of that; you have provided no advice to government around—

Mr Cormack: We did not say that at all. We just said that we do not have a consolidated document here to give to you or to talk you through, but we will take that on notice.

Senator SIEWERT: I am sorry if I have misinterpreted what I have just been told. You said there is no summary document being done. Has a summary been done?

Ms Cole: As the 31 PHN assessments come in, they are all assessed individually and we start to get a feel for where there are common themes across regions. That advice is provided to government as appropriate and as requested.

Senator SIEWERT: You have not done a formal summary across the nation, so we have no idea of those gaps across the nation. They have not been collected in one piece of work.

Ms Cole: What you are suggesting in your question, in a sense, is that the PHN's needs analysis is the only source of information around gaps in mental health services across Australia.

Senator SIEWERT: That is another question, which I will come back to. I want to know: have you done a complete summary—collectively, across the nation—of where the PHNs have identified gaps?

Mr Cormack: We are going to go around in circles on this.

Senator SIEWERT: You told me I had misquoted you, so I want to be clear.

Mr Cormack: Each PHN undertakes a needs assessment. They submit that needs assessment. It forms the basis of their commissioning activities, and their commissioning activities are meant to respond—and, indeed, do respond—to the needs that they identify. We collect that information for the purpose of monitoring the activity of the PHNs, and it also provides us with ongoing advice to be able to answer both systematic and ad hoc queries from government on a whole range of mental health matters. That information is there. Not every bit of information we collect gets automatically compiled into a single convenient document, because we collect lots of information through our program management activities. That is what I am saying.

Senator SIEWERT: Mr Cormack, you will be aware there is a great deal of concern about the gaps that are going to emerge with the closure of a whole lot of mental health programs and the transfer to NDIS. I would have thought that you would have been pulling this information together. Can I try again and ask it in a different way: what are the major themes that have emerged in terms of the gaps analysis that the 31 PHNs across the country have been doing?

Ms Cole: The issue around psychosocial support is not actually a PHN issue. We can talk to that issue now, if you wish. Some of the PHNs have obviously expressed the concern that the NDIS may result in some issues with or some gaps in the psychosocial area. That has been clear. Most of them—certainly the rural ones—have also indicated that workforce continues to be a major issue for them in addressing service problems, as you would expect—particularly psychologists. Some have identified some issues around the availability of psychiatry services and around things such as the need to develop appropriate low-intensity services. Essentially those are the kinds of themes that are coming out. I do not believe they are anything new to anyone who has been familiar with the sector for a while, but in a sense the NDIS issue of psychosocial provision of support is a slightly different issue from the PHNs themselves. Except where the PHN is actually a lead agency—for example, for partners in recovery—they do not have responsibility for those programs.

Senator SIEWERT: Can we go there, then? You mentioned that as the first issue that has come up. Would that be: how strongly across Australia has that issue been brought up? It was the first one you mentioned. I do not want to take anything from that without further discussion.

Ms Cole: This has an issue that has been raised by many stakeholders, including some of the PHNs. I believe that the national stakeholders have probably raised it more consistently than the PHNs. However, as I said before, it is not a responsibility of every single PHN; it is only where they also happen to be a PIR lead agency.

Senator SIEWERT: Have you conveyed the information you have just articulated, in particular the psychosocial issue, to the new minister?

Mr Cormack: First of all, the policy responsibility for the NDIS does not rest with this department. It rests with another department.

Senator SIEWERT: I will be following that up tomorrow.

Mr Cormack: That is good. Let me help you. You can ask them the questions, perhaps, that you attempt to ask us. We work very closely with DSS. Obviously, as the rollout progresses we feed into our DSS colleagues any issues that are emerging, any concerns that are being raised by the sector groups. I am sure you have had those put to you. Our job is to assist government and to assist the lead agency, which is DSS, to implement the transition through to the NDIS. We have responsibility for two programs and will continue to have responsibility for those right up until the end of June 2019. Over that time the clients in those programs will transition across. As we identify issues with transition at the level of the PHNs—some of the PHNs, but not all, are involved in a service provider capacity there—we provide that information to DSS to assist with the progressive implementation of the NDIS and, yes, of course we provide information to our minister to ensure that he is aware of this very important piece of program implementation. His responsibilities as a minister are with some of those specific programs that are transitioning. This is part of the process of providing ongoing policy advice to government, and we continue to do that right up until the present time.

Senator SIEWERT: I am aware that we have now got an inquiry into what is happening with these through the joint committee. I have lots of issues to pursue there. I will pursue them through there. I want to go to the issue of the mental health nurses and the incentive program. I will say 'mental health nurses', so you know what I am talking about. I am not talking about just the program. In an answer to a question that I asked last time, you indicated that it was not possible to tell how many nurses had ceased operation—how many services had ceased having a mental health nurse in place. Are you able to provide any information now on that?

Ms Cole: Senator, in this financial year there is a requirement for the PHNs to continue to fund wherever possible the current providers of mental health nursing services under that program. Some providers did not choose to continue. I can provide that on notice, but it will require actually ringing around each PHN and checking the details.

Senator SIEWERT: You have not required them to report to you?

Ms Cole: Not on the number of changeover in providers. Their obligation was that if a provider did not choose to continue under the old arrangements—say for example a GP practice—the PHN needed to find a solution for that mental health nurse and that mental health nurse's patients at that time. It is a changeover issue. I can find out for you how many providers they changed over in this transition year.

Senator SIEWERT: It would be appreciated if you could. Does that mean you are not monitoring it specifically?

Ms Cole: We are not monitoring specifically how much changeover there is in providers. In a sense, that becomes a subcontracting arrangement between the PHN and individual organisations. We can find that out for you. What we are more interested in is continuity of services for the patients concerned.

Senator SIEWERT: You are monitoring that?

Ms Cole: The continuity? Yes.

Senator SIEWERT: Could you provide us with an update on all the services being continued?

Ms Cole: It is a little bit difficult to do in the sense that people come in and out of services over the course of a year. What I can do is a bit of exception reporting and ask the PHNs to give us any indication where they had difficulty around continuing an individual patient's services.

Mr Cormack: Just to go back to this particular issue—the purpose of the mental health reforms was not to maintain in perpetuity the specific program elements that were in place. The essence of the reform that the government announced in November was to create a flexible, equitable funding pool for the PHNs to be able to respond to local measures. It was not meant to hardwire in all of the pre-existing elements of the programs that the government consciously decided to collapse into a flexible regional pool. There are transition arrangements, and that is what Ms Cole was referring to. At a certain point in time, MHNIP will be, as a program, something that has a history, but the service provision they are doing will become part of the flexible, locally responsive job of the PHNs. It is a transitional tool.

Senator SIEWERT: I understand the point you are making, and I understand the point you have made about the continuation of service. When you provide the additional information, could you give us a run-down of how you are doing that to ensure that it is in fact occurring? From your answer to the question from October last year, it is obvious that there has been a reduction in some of the mental health nursing services to a number of PHNs—it looks like a cut of more than 50 per cent in some of those cases. How did you think the PHNs were going to manage those cuts?

Ms Cole: There are only four that have had a dramatic change in the MHNIP's funding. You have to look at it as a whole. In the answer to that question we gave you the specific funding stream, because that was the specific question you asked. What you have to look at to see the whole picture are two things. One is: how much is available in other services through the MBS in that region, that PHN? If you look at, for example eastern Melbourne, it is very significant. There is a congregation of psychiatry and psychology services in that region.

Senator SIEWERT: You are saying that—

Ms Cole: I am saying that there are other options available to patients which the PHN is able to direct them to. The second thing to note is that the PHN receives an overall allocation into their flexible pool, and they are able to use that allocation as they wish to meet the patient needs in that population. The exceptions to that, longer term, are headspace and the EPPIC services, which are earmarked, at this stage, to the end of their funding cycle.

Mr Cormack: I will add a key point. There is increased flexibility, but there are also significant increases in funding, particularly in rural and regional areas, as a result of a more equitable distribution of the funding pool. That is what the reforms were partly about—to give PHNs greater flexibility where the historical program structures disadvantaged certain rural and regional areas that did not have a market, did not have a significant mass of particular providers. They, with more money, have been able to identify different ways of achieving the same aim—and that is what the government reform process was all about. It was about filling

those gaps, making it more flexible, not maintaining in perpetuity rigid program structures that advantaged certain regions in Australia to the disadvantage of others.

Senator Nash: I think this is really important. It was about enabling that flexibility so that local people were able to make the decisions locally and have more flexibility. With reforms of that kind, you are often going to get changes in services. It was very much about moving away from rigidity and—I know you understand regional areas very well—allowing that local decision making and local involvement.

Senator SIEWERT: I understand that, but—correct me if I am wrong—one of the issues here is that the NMHC did not recommend, or did not support, the mental health nurses program going into flexible funding. Is that correct?

Mr Cormack: We took the recommendations from the National Mental Health Commission report—which were about much more regional responsiveness—and we had an expert reference group guide the government in translating those into a government response. I will give you a couple of facts. Tasmania's allocation, as a result of this, has gone from \$827,000 to \$1.36 million. Let us look at another one. Country WA goes from \$1.135 million to \$1.878 million. You can focus on a couple of areas that were probably a bit oversupplied due to—

Senator SIEWERT: Probably—you do not know they were oversupplied.

Mr Cormack: Relative to those that were getting nothing or were getting half of what they are getting now, there is an issue of government responsibility to equitably and efficiently use its resources to be able to meet mental-health need in a geographically fair way. I have given you some numbers. We can give you the whole list if you like, but that is what it was about.

Senator SIEWERT: My question still stands. That particular program was not supported to go into the flexible fund.

Mr Cormack: The government responded fulsomely and wholesomely to the National Mental Health Commission report. It did it in November 2015, and we are implementing that. Everything that we are doing with these programs is in direct response to the November 2015 government response to the National Mental Health Commission report, which is on the public record. We are not going to go back and tease through all of the recommendations of the National Mental Health Commission. The government was clear and transparent in how it responded. It is on the public record. It made a very significant policy statement, and it has converted that into a series of budget programs that are now under implementation through our regional approaches. It is on the public record, and we are happy to provide you with all the information you need, particularly in relation to MHNIP or any other of those programs.

Senator SIEWERT: Are you going to do any analysis of the impact of the reduced number of mental health nurses in the areas where there is significant reduction?

Mr Cormack: We provided some transitional flexibility for those, and we will work closely with those particular PHNs and the College of Mental Health Nurses to identify any particular issues in those areas. But in many of those areas there are other options that are available to service the same need, and we will continue to work with the college, as we have since the reforms were announced.

Senator SIEWERT: I have had reports that there are a number of PHNs that are substituting nonclinical workers who do not have mental-health qualifications. Are you aware of this?

Ms Cole: PHNs are required to put in appropriate low-intensity services. A lot of PHNs, for example, have chosen to go follow the beyondblue NewAccess model in order to provide low-intensity services, which you could argue are coach-type positions, rather than a mental health nurse or a psychologist or whatever. The point is that they have been asked to do that. It is auspiced by beyondblue, who are having a strong quality assurance role in the rollout and implementation of those sorts of programs.

Senator SIEWERT: I was going to ask how you are assessing that, but is beyondblue doing that?

Ms Cole: Beyondblue is the owner of the concept, in a sense, and many PHNs have actually approached them and said, 'Can we work with you to implement the new access model in our region, as appropriate?'

Senator SIEWERT: What process are you putting in place to assess the assessor? I do not mean that beyondblue will not be doing a good job, but what process will you put in place to monitor that?

Ms Cole: One of the discussions we are having in this space with the other professional organisations, including the psychologists, the mental health nurses, the psychiatrists and the GPs, is around whether, in the longer term, there needs to be a formal accreditation process for low-intensity mental health workers.

Senator SIEWERT: What is the time frame?

Ms Cole: I believe that to set up a proper scheme would take at least two years, but those discussions are underway at present. Beyondblue is obviously the model that you would use as the baseline for such a system.

Senator O'NEILL: Perhaps take this on notice, as I am very mindful of time: what is the structure of the community consultation for the PHNs for the mental-health trial sites? Who invited them, how are they being facilitated, how many meetings—what is going on? Who has started and who has not started? Basically, I would like a Gantt chart of how it is rolling out and what is going on where. If possible, I would also like the names of the people who are the community representatives, so we can see who is engaged in this process.

Mr Cormack: We will take that on notice.

Senator O'NEILL: Thank you very much. There is \$46 million being allocated, I understand. Is that being allocated equally at all of the 12 sites?

Ms Cole: The sites are up to \$1 million a year for three years, plus the \$3 million for the evaluation. We are currently in discussions with the relevant PHNs around the funding arrangements for these particular sites. There is a thought that, for example, those in the remote areas of Australia will need slightly higher—within the cap of a \$1 million component—compared to a city one, just because the costs of running community adviser groups and, for example, facilitating community members to actually attend the meetings are a bit higher. That is just the administrative component, in the sense of running those trials.

Senator O'NEILL: Can you provide a time line around when each of the suicide prevention trial sites will actually start—at the various stages of engaging with the community and actually undertaking the trial? How long will the trial sites be active—how many years?

Ms Cole: Three years.

Senator O'NEILL: Three years—\$1 million for each of the three years of the trial?

Ms Cole: That is correct.

Senator O'NEILL: Will they all report in the same way or is that yet to be determined?

Ms Cole: All the PHNs will be required to work with the evaluator, when chosen, around common measures and common reporting—

Senator O'NEILL: So there will be a national comparative set of statistics that emerge from it?

Ms Cole: That is correct.

Senator O'NEILL: Do they report to the department or the minister? And how often?

Ms Cole: Sorry, which—

Senator O'NEILL: The trial sites.

Ms Cole: The trial sites are supported by the PHNs. The community advisory groups have a different set-up, depending on which one. For example, Minister Wyatt has chosen to chair the one in the Kimberley himself and has attended both meetings consequently. So it is going to vary a bit depending on the individual arrangements for each trial and what each community group actually wants.

Senator O'NEILL: Are the participants paid?

Ms Cole: No, the participants are not paid.

Senator O'NEILL: Are there any PHN based suicide prevention trial sites that do not have a lead agency role with regard to psychosocial support?

Ms Cole: Sorry, what did you say?

Senator O'NEILL: Are there any PHN based suicide prevention trial sites, of the 12 that we discussed, that do not have a lead agency role with regard to mental health service delivery?

Mr Cormack: We will probably take that on notice, because they are all a bit different. We will get back to you on that one.

Senator O'NEILL: Just following up, I did not pay attention to everything that you did with Senator Siewert. If you have not already, can you provide a clear list of which PHNs are lead agencies.

Ms Cole: We can provide that on notice.

Senator O'NEILL: Thank you very much.

Ms Cole: We will give you the specific topics in that context.

Senator O'NEILL: Did the former health minister want to expand the number of trial sites from eight to 12?

Mr Cormack: There was a commitment that was announced during the election campaign to increase the overall trial sites to 12. That was dealt with during the election campaign as a

promise and has now been brought to account through MYEFO. There are 12 sites. That is the relevant answer there.

Senator O'NEILL: I would like anything you can add, on notice, about why there was a delay in that being announced—about why it was February with the new minister. I would also like to get an update on the 31 Primary Health Networks and the work they are doing with regard to commissioning mental health services, as well as funding arrangements that are currently in place.

Ms Cole: Are you looking for a description of what each of them is up to?

Senator O'NEILL: Yes, can you provide the amount of funding each PHN receives for community-based mental health programs and services.

Ms Cole: Yes, we can provide that to you on notice.

Senator O'NEILL: Great. Do you have the quantum, and an average?

Ms Cole: The average would be misleading because there are very different population sizes. The total quantum for mental health funding through PHNs we can give you right now, when I find the right chart. In 2016-17, the total quantum was \$373 million.

Senator O'NEILL: And the year before?

Ms Cole: The year before they did not have funding.

Senator O'NEILL: Is there an anticipated budget going forward?

Ms Cole: In 2017-18, it is \$382.6 million in total.

Senator O'NEILL: 2018-19?

Ms Cole: 2018-19 is not contracted at this stage.

Senator O'NEILL: Of course, by PHN on notice if you can. Thank you very much.

Ms Cole: Yes.

Senator O'NEILL: Can you provide the amount of funding for each PHN with regard to suicide prevention programs and services.

Ms Cole: Yes, we can provide that.

Senator O'NEILL: Great. Do you have the quantum?

Mr Cormack: Yes, we do.

Ms Cole: We do.

Mr Cormack: The PHN suicide prevention networks over four years are \$37.6 million, then on top of that—

Ms Cole: It is over two years.

Mr Cormack: Sorry, it is over two years.

Senator O'NEILL: So it is for 2016-18—is that what you are talking about?

Mr Cormack: Yes, for 2016-18. That is \$37.6 million. For suicide prevention it is \$31 million—that is suicide prevention trials; and then on top of that there is obviously an evaluation component that goes with that. That is what is going direct to PHNs. In addition to that there is—

Senator O'NEILL: To be really clear about this, is the suicide prevention money that you are talking about there different from the trial sites that we have been talking about?

Mr Cormack: Yes.

Senator O'NEILL: So for the trial sites it is \$46 million—

Mr Cormack: No, no.

Ms Cole: Sorry, Senator. The \$46 million you are referring to is the total amount in the election commitment for suicide activities. It is comprised of the trial money,—

Senator O'NEILL: Which is?

Ms Cole: the evaluation money—

Mr Cormack: It is \$31 million for the trials and \$3 million for the evaluation. In addition to that there is \$12 million for the suicide prevention research fund.

Senator O'NEILL: So the \$37.6 million that you were referring to—

Mr Cormack: That is funding that is part of their flexible mental health allocation. That is directed towards suicide prevention at a regional level. In addition to that there is another \$52.3 million for national suicide prevention activity.

Senator O'NEILL: Is the amount for suicide prevention programs and services for each PHN additional to the general mental health funds?

Ms Cole: It is a part of the general mental health funds—those numbers that we gave you earlier, the \$373 million.

Mr Cormack: We will provide you with a detailed breakdown on notice.

Senator O'NEILL: I would appreciate it if you can, because there seems to be a bit of double counting in the way everything is done. I am certainly not getting any clarity about what exactly is there, and what is additional.

Mr Bowles: It is because everything is called 'suicide prevention', but there are different funds into different projects.

Mr Cormack: That is right. Some is pre-existing and some is new as part of the election commitments. We will provide you with a breakdown that identifies which stuff is new and which stuff is pre-existing.

Senator O'NEILL: Could you also provide a comprehensive list of the services that have been commissioned by each of the PHNs since they were established up until the end of this financial year?

Ms Cole: For suicide prevention?

Senator O'NEILL: Yes.

Mr Cormack: We will certainly take that on notice.

Senator O'NEILL: For mental health, broken down into any range of categories that you need to provide for us.

Ms Cole: Okay.

Senator O'NEILL: I understand that there is now a three-month delay in mental health plans that were supposed to be completed in March—they are not going to be completed until

July; and the commissioning of services that was due in July and is now not going to happen until September. Can you explain why that delay has occurred?

Ms Cole: I am not quite sure what you are talking about.

Senator O'NEILL: This is in regard to work plan delays.

Ms Cole: There was—

Senator O'NEILL: Mental health plans.

Ms Cole: There were regional mental health plans which each PHN was asked to do in conjunction with their state and territory, with their local area health services and community organisations.

Senator O'NEILL: They were commissioned to be completed by March, and due—

Ms Cole: They are not directly related to commissioning per se. Contracting has begun from 1 July, which has just been, and which is when the PHNs actually got the money. A number of them are now running commissioning services or have run commissioning services; most of them, in fact, have now completed their mental health commissioning things.

There was a separate requirement on them to work with the state governments in each region with their local non-profit organisations and so forth to develop a regional plan for the whole of the region about how mental health should be worked in conjunction with the local area health services, and so forth. That plan requirement was meant to be a second tier, I guess, in a sense of the Fifth National Mental Health Plan. Because that Fifth National Mental Health Plan is taking a little longer than anticipated to finalise with our state and territory colleagues, we have pushed that back so that they have that top tier—the top tier of the national plan—to then reflect in their regional plans in their discussions with the states and territories.

Senator O'NEILL: What does it mean for the continuation of services and programs?

Ms Cole: All services that were originally required or contracted are continuing.

Senator O'NEILL: Are you aware of any break in programs?

Ms Cole: Obviously, there is some movement within the PHNs where they have done their needs analysis, they have looked at what is currently funded in their region and they have compared that to their needs analysis, and then they have developed or commissioned new services as a result of that analysis. There is some change anticipated in how those services may be delivered.

Senator O'NEILL: I hear 'change' and I think continuity problems. Minister, can you guarantee there are going to be no service delivery gaps?

Senator Nash: That is certainly not the intention, Senator. I think we have been very clear about that.

Senator O'NEILL: I am sure it would not be the intention, but there has been mismanagement all the way through. There have been significant delays in this space and there are community groups and I am sure it is happening in your regional area where there is huge pressure on these services and people are very vulnerable because the geographical

location. Can you promise that there will be no interruption to services, no service delivery gaps, because of the delays?

Senator Nash: Senator, I am absolutely saying that that is the intention. You might want to drop in here with some process, but absolutely.

Mr Bowles: Senator, I reject the notion of mismanagement. I absolutely reject that for the record.

Senator O'NEILL: Thank you. It was raised in estimates last year that the PHNs are not able to commission psychosocial services and the department stated that PHNs have not been advised that they cannot commission early psychosis or psychosocial services. I want some clarification on that point, because I really cannot understand why the PHN guidance documents have included the directive that PHNs cannot commission psychosocial services.

Ms Cole: Senator, that is not 100 per cent true in the sense that there are a number of guidance documents around the priority areas of the PHNs in terms of what they need to commission. There is recognition in specific guidance documents that sometimes it will be appropriate to have a psychosocial element along with a clinical element for some priority areas. Youth is a classic example of that. Headspace provides psychosocial supports, general youth health service supports and mental health clinical services. That is perfectly appropriate and we have not told the PHNs that that is not appropriate, or that they cannot add onto those services as appropriate in their community. The broader issue raised by stakeholders around the NDIS and its impact is the perceived issue about what effect that has on the system as a whole.

Senator O'NEILL: 'Beware that danger lies here.' Is it the case that many if not all of the PHN needs assessments are showing psychosocial services and supports as their highest need?

Ms Cole: I think we have gone through this issue just quite recently.

Senator O'NEILL: There was a little bit of information there for Senator Siewert.

Mr Cormack: We will provide that to you on notice. We said there is not a consolidated document that we can present for you today, but we just said we will take it on notice so we will provide you with information around the outcomes of the gap analysis work that the PHNs have done. We will take that on notice.

Senator O'NEILL: Thank you, I appreciate that. Is it the policy or the process of the department that a PHN wanting to commission psychosocial services has to submit a request to the department and demonstrate why they should be able to commission these services?

Ms Cole: As I mentioned, under the guidance documents in certain areas they have the leeway to do that already. If they were wishing to—

Senator O'NEILL: So not all PHNs have to do this?

Mr Cormack: Senator, I think we are getting a few things conflated here. The first point here is that we have an NDIS program that is being implemented, which includes a psychosocial element, and I have given an answer on that and I do not think I need to elaborate on that.

Senator Nash: I might add that we have made some significant reforms in this area. We have fundamentally reformed the way the mental health services are delivered. You have been

asking questions for quite some time now, and given that historically the Labor Party in government said that mental health was a second term priority, this is a significant reform. There are, of course, going to be changes, but we are going to deliver Commonwealth services better than they have been delivered before.

Senator O'NEILL: My question remains though: do the PHNs have to contact the department before they can commission these services?

Ms Cole: All PHNs have to submit their activity plans for approval by the department before they can then turn that into contracting.

Mr Cormack: And that is not just mental health. That is not just psychosocial. They have to submit those plans and have a look at it and then, on the basis of that, they then go ahead with their commissioning arrangements.

I just want to go back to one really important conflated point: under the current arrangements a number of pre-existing Medicare Locals that have now been swept up into PHNs had direct service delivery responsibilities for certain psychosocial services that are now on the pathway to transition into the NDIS, but not all PHNs fit that category. Certainly, for any PHN that has inherited a service profile that is funded under Partners in Recovery or Day to Day Living, there is an expectation that they will continue to offer that right up until the point where it is fully transitioned into the NDIS. In that sense it is our expectation and, indeed, our commitment under the continuity of service arrangements that those services will continue. However, if there is a PHN that has no history in that space of providing or commissioning out of those two programs, we need to be mindful about a broader national rollout of an NDIS and not commission services that are already going to be funded and provided for under an expanded NDIS rollout from 2019-20. That is the point that we are trying to make. Not all PHNs are the same.

Senator O'NEILL: I understand what you are saying. It sounds—

CHAIR: Order! We will break now. When we resume we will continue on for a brief bracket of questions on this program.

Proceedings suspended from 16:17 to 16:32

CHAIR: We will reconvene the committee. Just by way of explanation, we are going to juggle things around a little bit again. With the indulgence of the committee, we are going to move to Program 2.4: Preventative Health and Chronic Disease Support for no more than five minutes with Senator Bilyk. Following that, we will have a bracket of questions from Senator Kakoschke-Moore on program 2.3: health workforce, and then we will go back to conclude mental health with Senator O'Neill, Senator Siewert and Senator Roberts. So Senator Bilyk, as the officers for program 2.4 come to the table, over to you.

Senator BILYK: Thanks, Chair, and thanks, committee, for being so accommodating. I think this will only take five minutes—and in fact it might take less time after the first question. At the last estimates round, Senator Polley asked, on behalf of me, about an evaluation of the Better Access to Palliative Care program by Australian Healthcare Associates. Has that evaluation been completed?

Mr Bowles: I will just find the correct page—they tell me that is under hospitals.

Senator BILYK: I just know that four times we checked where it came up and we were told, 'No, we checked four times' and the secretariat checked. We were definitely told it came

up under theirs—2.4, including palliative care. It is the Better Access to Palliative Care program.

Mr Bowles: Yes, I will have a crack at that.

Senator BILYK: Do you just want me to ask the question again?

Mr Bowles: Yes, please.

Senator BILYK: At the last estimates round, Senator Polley very kindly on my behalf, asked about an evaluation of the Better Access to Palliative Care program by Australian Healthcare Associates. Has that evaluation been completed yet?

Mr Cormack: We received it in December; we are still considering it.

Senator BILYK: What is the time line?

Mr Cormack: As soon as possible.

Senator BILYK: Can you be a bit more specific? 'As soon as possible' to me was actually about three months ago before Palliative Care Tasmania had to close its doors

Mr Cormack: Sure. We have the evaluation and we are working through that. But, as you are aware, that was part of a package of measures that have come to an end.

Senator BILYK: I am aware of that, but I am specifically asking about the Better Access to Palliative Care program that was to be evaluated.

Mr Cormack: I cannot tell you honestly today exactly when it will be ready for any further formal consideration by government. All I can tell you is what I have already said—we have the evaluation and we are working through that. As you know, we have had a change of minister and that is also an important thing to take into account. As I have mentioned before, it will certainly be useful for us to consider the findings of the evaluation and to have a look at how it might inform other palliative care activities, but that funding line to Tasmania has effectively come to an end. There is some continuation of service for a short period of time—

Senator BILYK: Just because they were good money managers. That is the only reason.

Mr Cormack: Quite possibly.

Senator BILYK: That is the only reason. Will the report be publicly available then?

Mr Cormack: We have not really had the opportunity to work this through with the minister.

Senator BILYK: How long have you had it?

Mr Cormack: I think December is what I advised—

Senator BILYK: Eight weeks or so.

Mr Cormack: Yes, we have had it eight weeks or so.

Mr Bowles: We have had a new minister, as well.

Senator BILYK: In the meantime, people are dying without access to palliative care—or enough access.

Mr Cormack: The point we are making is that the government's position on that program is that it was meant for a fixed period of time, that time has elapsed; we will certainly get

some useful learnings from the Tasmanian evaluation but there is not a government decision to put any more funding into the program.

Senator BILYK: I do have some other questions but I am happy to put the rest on notice after those responses. Thank you to everyone for their consideration.

[16:37]

CHAIR: Thank you, officers, for your flexibility. Senator Kakoschke-Moore, we are now dealing with your bracket of questions on program 2.3, health workforce.

Senator KAKOSCHKE-MOORE: Thank you, Chair, and thank you to the committee for being so accommodating with the rearrangements this afternoon. My questions will focus around the CRANApplus report that was released a little earlier this year—'*Remote health workforce safety and security report: literature review, consultation and survey results*'. The department commissioned this review and it was released a little earlier this year. When can we expect a departmental response to this report?

Dr Southern: They released that report on 18 January, I understand.

Senator KAKOSCHKE-MOORE: Correct, yes.

Dr Southern: You are asking about the departmental response. My understanding is that that report is under consideration in the department at the moment. As you know the issue arose out of a particular issue in South Australia and then a discussion at a rural health roundtable that, in fact, Minister Nash, I believe, chaired when she was responsible for rural health. It is really a question of us having a very close look at what has come out of the report before we put together the response.

Senator KAKOSCHKE-MOORE: And there will be a formal response released at some point?

Mr Hallinan: Yes, we will be putting that report to the rural roundtable, which will now be chaired by Minister Gillespie, and seeking a response through that process.

Senator KAKOSCHKE-MOORE: When is the meeting of the roundtable?

Mr Hallinan: I believe around May is the next meeting.

Senator KAKOSCHKE-MOORE: During that meeting the report will be considered and a response formulated following the feedback from the members?

Dr Southern: That is correct. CRANApplus is a member of the stakeholder roundtable.

Mr Hallinan: The report covers a range of areas including responsibilities outside that of the department or the Commonwealth, and it goes into areas of community controlled sector remote area services provided by the states and territories. So it requires a response from a broader perspective.

Senator KAKOSCHKE-MOORE: Will the response consider the 31 recommendations that were made in the report? Will there be a formal response to each of those recommendations?

Dr Southern: I think we will have to have a closer look and a think about how we respond. It may well be that the recommendations are grouped into themes, for example. Often a response might be along those lines. As Mr Hallinan said, not all of it falls within Commonwealth responsibilities.

Senator KAKOSCHKE-MOORE: Is the department planning on providing to further the recommendations in this report?

Mr Hallinan: We have no specific budget allocated to respond to the report, but how we administer our programs and any supports that we can do through our existing program structures would be something we would consider.

Senator KAKOSCHKE-MOORE: Is there funding available within your funding pools that could be attributed to the recommendations that have been made in the report in order to enact them?

Mr Hallinan: Ultimately that would be a decision for a minister. I think we have a suite of around 40 programs, many of which target rural distribution and access in rural areas. The recommendations that can be taken on board in the administration of those programs, I think, we would take on board through usual management processes.

Senator KAKOSCHKE-MOORE: Has the roundtable that will be considering this report met since the report was released in January?

Dr Southern: No, it has not.

Senator KAKOSCHKE-MOORE: Okay, so the first meeting of the roundtable is in May?

Dr Southern: Yes, I think it is May.

Mr Hallinan: We will confirm if it is not.

Senator KAKOSCHKE-MOORE: Thank you. I understand that in January 2009 the Australian Health Ministers' Advisory Council tasked the rural health standing committee to develop a National Strategic Framework for Rural and Remote Health. The National Strategic Framework for Rural and Remote Health was developed through collaboration between Commonwealth, state and Northern Territory governments by the rural health standing committee and it presents a national strategic vision for health care for Australians living in regional, rural and remote areas. This particular document that was developed does not refer to the safety of health workers in rural and remote areas either as a challenge or a consideration within health workforce considerations. Are there plans to update this document following on from recent projects such as the CRANaplus report?

Dr Southern: There is no specific plan to do that, but in considering the CRANaplus report and the conversations that we might need to have with our jurisdictional colleagues, that is a possibility, but no decision has been taken to update the framework in that way. I do know that certainly the Northern Territory and possibly South Australia and Queensland—I cannot remember now—have already taken steps to implement their own frameworks around the safety of rural health workers, so they have their own arrangements in place.

Senator KAKOSCHKE-MOORE: When will a decision be made whether or not to amend this document?

Dr Southern: I think it would be part of the discussions at the rural roundtable in response to the CRANaplus report. Certainly at the original roundtable discussion about this matter, there was discussion about how we engaged more broadly with the states and territories around these things, but, as I said, a number of the jurisdictions have independently taken that action anyway.

Senator KAKOSCHKE-MOORE: Will the rural roundtable meeting in May be taking place before or after the next round of Senate estimates?

Dr Southern: I do not know the answer to that.

Senator KAKOSCHKE-MOORE: I am just thinking about follow-up questions that I will have based on the meeting of the rural roundtable and whether or not I can pursue those during the next round of estimates.

Dr Southern: We can come back with the date on notice, if it has been set.

Senator KAKOSCHKE-MOORE: That would be great, thank you. The CRANApplus report states that within the questionnaire that was distributed participants reported that Aboriginal and Torres Strait Islander communities in which they worked often did not have Aboriginal and Torres Strait Islander health workers. It says:

The absence of Indigenous clinical staff impacts negatively on both the cultural safety of services available to communities, and the safety of RANs—

remote area nurses—

and other members of the remote health workforce.

Do you consider that there is a shortage of qualified Aboriginal and Torres Strait Islander health workers?

Dr Southern: The numbers of Aboriginal and Torres Strait Islander health workers have been growing substantially over the last few years, which is a very, very good sign, but undoubtedly there would still be some areas where Aboriginal and Torres Strait Islander health workers were not available.

Senator KAKOSCHKE-MOORE: Perhaps on notice you could provide the committee with the number of Aboriginal and Torres Strait Islander health workers currently employed.

Dr Southern: Certainly.

Senator KAKOSCHKE-MOORE: I understand that there are some representative groups that have asked for increased scholarships for Indigenous students to study nursing, midwifery and medicine. These groups that are calling for the increased funding for scholarships provide culturally relevant programs to assist students who face various challenges in completing their studies. Do you recognise the need to provide support mechanisms for Indigenous students by way of means such as scholarships? Does the department have the capacity to provide more funding in order to establish more scholarships?

Dr Southern: The department currently manages a program of scholarships which are specifically for Aboriginal and Torres Strait Islander students. My recollection is, again, that that program has grown in recent times and continues to grow. So there are dedicated scholarships for Indigenous students across a number of health professions.

Senator KAKOSCHKE-MOORE: Are there any plans to increase the number of scholarships?

Mr Hallinan: No, there are no plans to increase the number of scholarships at this time. There are plans to introduce changed methodology around how to target scholarships in our mainstream scholarships programs from profession specific scholarship streams to a local

needs based identification system. Local communities would identify the highest need professions and skill sets for their areas and scholarships would then be targeted on that basis.

Senator KAKOSCHKE-MOORE: On notice, could you provide me with some more information around the number of scholarships and the changes that you are making to a more targeted approach to providing those?

Dr Southern: Yes, of course.

Senator KAKOSCHKE-MOORE: Is it the case that, while the Aboriginal and Torres Strait Islander Health Plan exists, there is no strategy in relation to the Aboriginal and Torres Strait Islander workforce?

Dr Southern: No. There is a national Aboriginal and Torres Strait Islander workforce strategy, or framework—I cannot remember the correct language. That is work that is undertaken between the Commonwealth and the states and territories under the auspices of the COAG health ministers council and, beneath that, with the Health Workforce Principal Committee. Mr Hallinan co-chairs the Aboriginal and Torres Strait Islander Health Workforce Working Group.

Senator KAKOSCHKE-MOORE: I am aware that a group known as the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives wrote to Minister Ley last year, I believe in December, in relation to the issue of embedding cultural safety into health practitioner regulation law. This would involve a professional development requirement that addresses racism and discrimination, power imbalances and the impact of culture. These matters are not addressed in regulation or legislation currently, and it is my understanding that this correspondence has not yet been responded to by the new health minister. Do you consider that there is a need to address these cultural safety issues within the entire health workforce?

Mr Hallinan: That matter is being considered through the auspices of health ministers at the moment, through review of the National Registration and Accreditation Scheme for the health professions. So the same proposal has been put to the Health Workforce Principal Committee, which is a subcommittee of health ministers, and it considers the legislative arrangements and frameworks that support health professionals and regulate the profession. I think there are two tranches of legislative reform that are being proposed through that process. The first tranche will be entered into the Queensland parliament—it is a state based law rather than a Commonwealth based law—in the coming months, midyear. And I believe that the matter of embedding cultural safety into the national law or regulatory arrangements is being considered as part of the tranche to reform process.

[16:51]

CHAIR: For our next round of musical chairs, we are going to go back to program 2.1, to conclude consideration on mental health. We will go first to Senator Roberts on that program.

Senator ROBERTS: Thank you for being here today. We travel frequently throughout Queensland and we know that suicide is a serious problem in our state, especially among farmers and veterans who suffer from PTSD. The Murray-Darling Basin Plan, family law—there are many, many serious concerns that we have from our constituents. Can you please advise how many Australians commit suicide each year?

Ms Cole: The figures are for deaths per 100,000. In last year's figures, the national average was around 12.7 per 100,000, but I will just check that—

Mr Cormack: There were 3,027 deaths registered in 2015 as suicides, and, as Ms Cole said, it is equivalent to a death rate of 12.6 per 100,000 population.

Senator ROBERTS: So just on 3,000?

Mr Cormack: Yes—3,027.

Senator ROBERTS: This is out of personal interest: I understand that, in Sweden, sometimes single vehicle accidents are treated as suicides, and I imagine the definition around the world varies; is it possible that it could be much higher than 3,000 or slightly higher than 3,000?

Ms Cole: The 3,000 number is the number found by the coroners, and coroners do take into account issues such as single vehicle accidents and so forth.

Senator ROBERTS: Can you advise as to what the suicide rate is for men aged 44 to 49, because you have said that the suicide rate for Australians is 12.7 per 100,000 people.

Mr Cormack: I do not think we have that with us right at the moment, but we will get that figure for you, hopefully before we break today.

Senator ROBERTS: Can you advise as to how many men aged between 20 and 24 take their lives?

Ms Cole: Would you like a table which—

Senator ROBERTS: Yes, please. How about the rate in the Northern Territory?

Ms Cole: We can get that to you on a state-by-state basis as well.

Senator ROBERTS: And particularly for the Northern Territory. Would you agree that this is an important issue that transcends age, gender, ethnicity or geographic region and that it needs to be addressed?

Mr Cormack: I think that there is little doubt that the rate of suicide is of enormous concern, and certainly the government has recognised that in a number of quite significant new initiatives. Just for the record, over the four years from this year through to 2019-20, there will be just under \$136 million that will be invested in suicide prevention activities. Some of that has just been additionally committed through the election commitments that were dealt with and funded through MYEFO. I think all governments recognise that this is a critically important issue. Certainly, it does cut right across society. There are particular groups, in particular geographical regions, where there is a significantly higher burden. Certainly, I think the government has indicated that it will continue to be a priority. Indeed, Minister Hunt has identified mental health right up there in his top areas of priority. So I think we can take that there is no disagreement at all with the importance of this as a health issue and the need to: do our best as a country and as a government; probably just as importantly, do our bit at a regional level and at a community level to identify the risks to support those more vulnerable parts of our population that are more susceptible to this; and ensure that when the government invests additional money into that it is invested wisely and evaluated appropriately.

Senator ROBERTS: That goes to the next question I have. Has there been, or is there, a comprehensive cost-benefit model that demonstrates which sorts of programs are most effective in suicide prevention?

Ms Cole: The answer on that is: not really. There are a number of accepted methods of reducing suicide, in particular community-based prevention trials. I can find out for you whether there has been a specific cost-benefit analysis. But, essentially, the consensus is that you need a system-wide approach to suicide prevention, which includes eight or nine factors being addressed within a high-risk community at once in order to bring those numbers down to a more acceptable level.

Senator ROBERTS: It is certainly a complex issue. I have been to quite a few places where people have volunteered that if we could fix basic systems like tax systems, farmers' property rights and family law, then things improve. Even simply improving the economy again and getting jobs moving in rural Queensland will help to reduce the suicide rate. So I understand it is complex. Is there any comparison of, or any evaluation of, different programs whose targets vary—for example, in family law or custody disputes versus farmers in rural areas. In other words, geographical—I guess not, because of your previous answer.

Mr Cormack: That is very good question. I think we will just need to take that on notice and give you a considered response to that.

Senator ROBERTS: It is stated in the current National Mental Health Commission budget statement that its main task on establishment was to deliver an annual report card on mental health and suicide prevention. However, only two report cards have been produced—one in 2012 and one in 2013, and then the response to the 18 recommendations in 2014. Are the missing annual report cards produced by the commission forthcoming?

Mr Cormack: That is probably a question that is best addressed to the National Mental Health Commission. I think they are on the program.

Mr Bowles: They are coming to the table now.

Dr Brown: Yes, you are correct, Senator. There were two reports—the 2012 and the 2013 annual reports. In 2014, we did the response to the recommendations from the previous two reports. At the end of 2014, we completed our review of mental health programs and services, which we presented to government. That is the big review, which has already been mentioned here today. In 2015, we were awaiting the government response. So there was no report produced in that year. For the 2016 year, there is a report currently in draft. It is awaiting finalisation. We have had a change in staffing at the commission which has, I think, contributed to the slight delay in terms of producing that report.

Senator ROBERTS: Okay, thank you. What changes have been made by the government in relation to the review of programs by the National Mental Health Commission?

Mr Cormack: Just to step you through that, in November 2015 the government issued a comprehensive response to the National Mental Health Commission's report. It effectively addressed nine key areas of reform. We have touched on some of those today. The first of those—and we have talked a lot about this—is locally planned and commissioned services and flexible primary healthcare funding pools. That has been established and, indeed, the PHNs are now commissioning that. The government essentially collapsed down nearly 20 programs—I will give you that precise number on notice—to a smaller number of programs

to give much greater local accountability and local responsiveness to the commissioning of mental health services.

The second key element that the government committed to was establishing a new digital mental health gateway, recognising that the government currently funds over 20 organisations to provide a range of telephone and internet based services for people with mental health information needs or assessment and treatment needs. That work is now progressing.

The third element in the government's response was refocusing primary and mental health care services to support a stepped care model, which essentially means you do not have a one-size-fits-all approach. You are able to be flexible as clients move in and out of the service system and their needs change. They may have a very acute or crisis service response requirement and then be treated and require a lesser degree of support. The system is flexible enough to be able to respond to their particular needs.

The fourth area was joined up support for child mental health. That is recognising that there are a number of national programs that have over the years grown up to respond to the needs of children and young people. So we are now working through the process of starting to consolidate some of those. Probably one of the most significant areas of reform is an integrated and equitable approach to youth mental health. The centrepiece of that program is headspace. The government has made additional commitments to increase the number of headspace centres. It also has changed to a locally and regionally responsive model through the commissioning of headspace services at a regional level through PHNs while maintaining that essential national support function of the headspace national office.

The sixth area is integrating Aboriginal and Torres Strait Islander services. We have talked a little bit about that today, particularly in the context of suicide prevention.

CHAIR: I am just cognisant of the time. I am just wondering how many more areas there are to cover, because Senator Roberts' time is up.

Senator ROBERTS: Perhaps I should just put the rest of my questions on notice.

CHAIR: That would be helpful, yes. Sorry to cut you off there, Mr Cormack.

Senator SIEWERT: You touched on headspace, Mr Cormack. I have a question on that. Are the processes to establish the new headspace centres going to be the same as applied to previous ones or are they different?

Ms Cole: It is largely the same in that we used the basis of the model which headspace had used and which we developed in conjunction with headspace in around 2009. That looked at population service delivery and those sorts of demographic issues. We added an element this time. We sought bids from PHNs based on their needs analysis to see whether they also agreed with the national modelling.

Senator SIEWERT: Can you say that last bit again?

Ms Cole: We asked the PHNs to bid to indicate whether they believed that it would be appropriate to have an additional headspace within their region so that we could compare the local analysis with our national modelling.

Senator SIEWERT: I will indicate that I have a number of questions around various issues to do with a further analysis of headspace that I will put on notice. But I did want to go

to the Better Access program. Is it appropriate that we deal with it here or should it be in aged care?

I want to specifically deal with it as it relates to residential care.

Mr Bowles: Do you want to know about health issues in aged care?

Senator SIEWERT: No, I am asking specifically about Better Access and the issue around access to that program in residential care.

Senator POLLEY: I have a heap of questions for that in aged care as well.

Senator SIEWERT: Is it better to ask it—

Mr Bowles: Obviously, we were aware that this might come up and we have agreed amongst officials that it is probably best dealt with in the mental health outcome area. It is a mental health program—

Senator SIEWERT: That is what I thought you would say, which is why I was asking the question.

CHAIR: Is that time we will take off the aged care component?

Senator POLLEY: I did not say that!

CHAIR: I did, though!

Senator POLLEY: They are changing things without letting us know.

Senator SIEWERT: Well, it is not changing things, because it is actually a mental health program, which is where I expected this would be.

CHAIR: We will talk about it.

Senator WATT: I think we can probably live with that, provided we have an opportunity later this evening to deal with some of these issues. Can we have the same people stay behind to deal with these issues, whether it be in the aged-care section or after some other questions in outcome 2 get asked?

Senator POLLEY: Otherwise we are going to be even further behind.

Senator WATT: Yes.

Senator Nash: Is that a direct swap in time length?

CHAIR: That would be my intention, that whatever—

Senator Nash: Is the amount of time that you would need later the same amount of time that you would need now with—

Senator WATT: Yes, but we had planned other priorities to deal with in this outcome. We were not aware that this was going to be dealt with now. We thought—

Senator SIEWERT: I was not aware I was required to tell you what my questions were—

Senator Nash: Isn't that still a just a simple time toss?

CHAIR: I guess the only thing is the opposition's—

Senator POLLEY: Not if people have to be elsewhere.

Senator Nash: That's right; that is a fair call.

Senator SIEWERT: If we want to leave aged care, it seems silly to have it, then not have it and then go back to it. I am happy to wait, as long as it is clear that I will get an opportunity to ask some questions.

CHAIR: Will that work? Okay.

Mr Bowles: The same people are going to have to come back to the table later on.

CHAIR: Okay, let's do that.

Senator O'NEILL: Just following up on the questions surround headspace, I notice that Mr Hunt announced that Grafton would be the first location in Australia to get one of 10 new headspaces. Was that selected on the basis of the model you just described—the population, service delivery and the PHN request?

Mr Cormack: As Ms Cole said, we provided a comprehensive package of information along the lines of what Ms Cole said. At the end of the day the decision for the final additional 10 sites that were announced as part of the election campaign was ultimately a matter for the government to take. We provided a comprehensive set of advice and information to enable the government to make its decision.

Senator O'NEILL: How many sites did you provide as options for the government to choose from, based on your criteria?

Mr Cormack: At this stage the government is still working through the advice that we have given it. The minister chose to make an announcement last week—

Senator O'NEILL: About one of them.

Mr Cormack: and the timing and the consideration of the additional nine headspace sites is ultimately a matter for government consideration.

Senator O'NEILL: The other nine, you mean?

Mr Cormack: The other nine, yes.

Senator O'NEILL: Minister Nash, do you know where the government will locate the next nine headspaces?

Senator Nash: I am not aware of that, but I can take that on notice for you.

Senator O'NEILL: And is there any work being undertaken by the government in addition to what the department has spoken about?

Senator Nash: I will have to take that on notice for you.

Senator O'NEILL: Thank you. Could I go on to the NDIS? I am particularly keen to ask about this for people with mental illness who will be ineligible. Firstly, can you provide details about how much funding has gone into PHaMS, Partners in Recovery and Day to Day Living on an annual basis since 2013? Can we do them one by one? PHaMS?

Mr Cormack: We do not cover PHaMS, we cover Day to Day Living and Partners in Recovery.

Senator O'NEILL: Right. If you give me those, that is fine.

Mr Cormack: Yes, we can do that. The program funding for Partners in Recovery from 2014-15—

Senator O'NEILL: Can you do it from 2013?

Mr Cormack: I do not have that. I have the five years from 2014-15, if you would like me to take you through that?

Senator O'NEILL: Yes, that would be great. And if you could do 2013 on notice, that would be good.

Mr Cormack: For Partners in Recovery 2014-15 is \$132.5 million, 2015-16 is \$157.1 million, 2016-17 is \$143.9 million, 2017-18 is \$145.9 million, and 2018-19 is \$148 million. That is the five-year funding allocation.

Senator O'NEILL: For Partners in Recovery?

Mr Cormack: Partners in Recovery. And for day-to-day living, going through those five years, it is: \$14.78 million, \$14.78 million, \$14.99 million, \$15.48 million and \$15.7 million. We will come back to you with the 2013-14 figures.

Senator O'NEILL: With regard to the eligibility of the NDIS for people with mental illness, we have raised this issue before in the last estimates. There were questions that were asked but we did not get anywhere. There seemed to be some interesting conversations around the shifting of responsibilities between the Department of Health and the Department of Social Services, but I would like to revisit the area and see if there has been any work done in the interim period of the last four months. Are you in a position to provide an update on which department is responsible for people with severe mental illness that fall outside of the NDIS?

Mr Cormack: That is not a clear-cut question. There is a cohort of people with severe psychosocial mental health issues that will be transitioning into the NDIS program, and the department responsible for that program is DSS. That has always been clear cut. In terms of the overall responsibilities for people who may not fit into that program, it still remains a mixture of responsibilities between the Commonwealth and the state government, depending upon the nature of the service need that is required. For example, if those people required acute admissions or ongoing care in a mental health facility, that is clearly a responsibility of the state and territory governments, and the crisis-related service responsibilities have typically been the responsibility of the state and territory governments. That is pretty much the way it is.

Senator O'NEILL: I am aware of that. I have only got a very short time. If you could give me a clear and short answer to this question: who is responsible for those who are not eligible and fall outside the NDIS?

Mr Cormack: The continued responsibility is the Commonwealth and state governments for their health-related services.

Senator O'NEILL: Within the Department of Health?

Mr Cormack: These people have other sorts of needs as well that sit outside the responsibilities of the Commonwealth and state health authorities.

Senator O'NEILL: But their health care remains with Health in joint responsibility?

Mr Cormack: Their clinical health-care needs remain the responsibilities of the Commonwealth and state governments, depending upon the nature of their particular illness and need at a point in time.

Senator O'NEILL: Has the Department of Health done any modelling assessment or analysis on the number of people with mental illness who will not be eligible for the NDIS or how many people currently using Commonwealth-funded mental health programs will be NDIS eligible?

Mr Cormack: We are working very closely with DSS, who have responsibility for the transition arrangements. In addition, as you know, the Productivity Commission has been tasked with a new piece of work to revisit some of the initial costings in funding arrangements for the NDIS. There is a range of information that has been developed historically by the Productivity Commission and, no doubt, those numbers will be revisited. That is another piece of work but, again, that is a policy issue. The question is best directed to DSS, not Health, or to the Productivity Commission if you want to know more about that particular piece of work.

Senator O'NEILL: So you have not done any modelling as a department?

Mr Cormack: We do not do detailed modelling of this type of activity. We obviously have a good, close look at the service needs of those people who may require services that are funded by the Commonwealth. The state similarly does that with their services.

Senator O'NEILL: I know. Mr Cormack, sorry, if I had more time I would listen more gently but I am going to be a bit bruising here. Have you got a number for the number of people who will need mental health programs that are NDIS eligible?

Mr Cormack: The policy responsibility for this rests with the Department of Social Services. We are not responsible for the modelling of that program. All questions on that should be referred to the responsible policy agency.

Senator O'NEILL: Thank you. Last December, *The Australian* ran a story on official modelling. Included in the article was a reference to state modelling undertaken for all health ministers by the New South Wales and Queensland governments. These figures suggest—and I am sure you are aware of it—that more than 100,000 people will not be eligible for the NDIS. Have you seen this modelling? Are you aware of that?

Mr Cormack: I have seen a lot of material in the public arena speculating on the potential numbers of people who are either in or out of the NDIS arrangements. I have not heard a precise figure of 100,000, but I have heard many different sorts of figures. As I said, the responsibility for this rests with DSS.

Senator O'NEILL: In the article, there was also a response from a spokeswoman, who was not from the Department of Health; it was a Social Services spokeswoman. She said: Any of our commonwealth clients who are not eligible for the NDIS will receive continuity of support. Can you explain how these clients who fall out of the NDIS will receive continued support, and what planning are you doing for that?

Ms Cole: We are watching, very closely, the numbers as they transition in different regions, and we will work with our colleagues in the Department of Social Services, and our state and territory colleagues as well, around ensuring that the government's commitment around continuity of support is realised in due course.

Senator O'NEILL: Can I close with this. This is the last question. I am sure that you are very aware of the distress that exists in the community at this point in time. The last thing

they want to hear is people in Canberra saying, 'It's not my responsibility; it's another department.' They want to know that the people they love, who are currently receiving care in community, are going to continue to have that care. So my last question to you, for those people who want to hear that question—not for me as a senator but for the community—is: what is the department's advice to those people experiencing a mental illness that currently do not know if they will be supported if they are not eligible for the NDIS? What do you have to say to them? They are listening.

Mr Cormack: What I will say, and what I have said before, is that the policy responsibility for the NDIS rests with another department.

Senator O'NEILL: Their care is provided through Health. They need a better response.

Mr Cormack: Today, but it is transferring.

Senator Nash: To be really clear for those people who are listening, I understand, and I think everybody in the government does, that there are concerns around the day-to-day living and Partners in Recovery, and mental health is an enormous concern, but that is why we extended the funding out to 2019: so we have time to make sure this transitions properly. So I think the last thing we need to do is have people be worried that it is going to suddenly fall off a cliff, when we have extended the funding till 2019 for precisely the reason of getting the transition in place.

Senator O'NEILL: With respect, Minister, though, as it is rolling out, there are people who are falling off. That is the problem.

[17:18]

CHAIR: Order! We will now conclude our consideration of program 2.1, Mental Health—sorry to cut you off, Senator. Thank you very much for your patience, and thank you for truncating questions, Senators.

We will now go to program 2.4. There is just one small housekeeping matter: we are going to do a little bit of juggling at approximately 10 to six to accommodate Senator Urquhart. We will have two brackets of 15 minutes of questions in 2.4, starting with Senator Watt, and then I will go to Senator Leyonhjelm. Then, at approximately 10 to six, we will jump to program 2.7 for about five minutes of questions. Then we will revert to program 2.4. Again, apologies for this, but it is the best way.

Senator SIEWERT: Can I just clarify: when we go to 2.7, which I am happy to do, are we going to deal with all of that outcome then before we go back.

CHAIR: No, it is just for the purposes of Senator Urquhart, and then we will go back to the program.

Senator WATT: The first round of questions I have is about plain packaging laws, which we began to talk about this morning but agreed to deal with now. I would like to ask about the department's administration of the Tobacco Plain Packaging Act. How many acts of noncompliance with the Tobacco Plain Packaging Act have there been?

I am looking for information from the 2014-15, 2015-16 and 2016-17 financial years.

Dr Southern: I have a cumulative figure, which perhaps I will start with, and we might have to take on notice the breakdown over the years that you mentioned. As at earlier this month, the department had received 1,054 individual complaints since tobacco plain

packaging came into full effect on 1 December 2012. They related to 746 cases, because some of the complaints related to the same supplier or retailer. Last year, 2015-16, we received 679 complaints, giving rise to 375 cases. Complaints, obviously, are followed up by us. On most occasions, suppliers are found to be compliant, although some cases require further attention. As at 6 February, so earlier this month, 459 cases had been closed as being found to be compliant.

Senator WATT: 459?

Dr Southern: Yes. That was out of the cumulative total of 746 cases that I mentioned earlier.

Senator WATT: So 459 of the 746 cases, and what we mean by that is that there could be more than one complaint about—

Dr Southern: Yes.

Senator WATT: When you say 'case', are you talking about a particular brand—

Dr Southern: Yes, or a particular outlet.

Senator WATT: or a particular product or outlet?

Dr Southern: Yes, that is right.

Senator WATT: And 459 of those cases were closed—

Dr Southern: As found as being compliant.

Senator WATT: which leaves just under 300?

Dr Southern: Yes. One hundred and seventy-five warning letters have been issued; 124 reinspections have been conducted; and four infringement notices have been issued.

Senator WATT: You were able to give me figures for 2015-16.

Dr Southern: That is correct. I do not have earlier years for the individual annual figures.

Senator WATT: What about 2016-17, the year we are currently in?

Dr Southern: I do not have that breakdown, no. On notice, we can provide you with the breakdown for 2016-17 to date. We will include the 2015-16 figures, and then it was the previous—

Senator WATT: 2014-15 as well, yes. You have no sense at all of whether that number in 2015-16 was an increase on the previous year or a decrease?

Dr Southern: I do not know if my colleague can assist.

Mr Masri: No. It is another matter I think I will have to take on notice and get back to you.

Senator WATT: You do not have those figures with you, Mr Masri?

Mr Masri: No. I think the ones that the deputy secretary—

Senator WATT: How has the department gone about enforcing the act when it detects noncompliance?

Dr Southern: Any complaint is followed up with a field inspection. We do our compliance work through the National Measurement Institute, which is part of the Industry portfolio. They largely conduct the compliance activity for us. They would inspect

manufacturers, suppliers or retailers, whoever had been the subject of a complaint, to see whether there was any material, basically, saying that there had been a breach of the act.

Senator WATT: Has the department fined any company for noncompliance with the act?

Dr Southern: Yes, we have. I am just looking for the data. Sorry, I think I will have to come back to you on that one.

Senator WATT: Okay. While you are at it, can you tell me what the fine was, when it occurred and what company?

Dr Southern: Yes.

Senator WATT: Again, I would appreciate getting that this evening if there is something that you can—

Dr Southern: Somebody has found the relevant bit. This goes back to June 2015, when a search warrant was executed on a retailer here in the ACT. A penalty of \$2,040 was imposed and paid for non-compliant cigars. It was in response to an infringement notice that had been issued by the department.

Senator WATT: Is that the only fine that has been issued under this legislation?

Dr Southern: I believe so, yes.

Senator WATT: I think you were telling us before that this legislation has been in place since—

Dr Southern: 2012.

Senator WATT: 2012; there have been over 1,000 complaints, albeit 746 cases—and I accept that a number of those cases were found to be compliant—but there has actually only been one fine issued and only four infringement notices in total in four and a bit years?

Dr Southern: That is correct. And the four infringement notices actually related to only two cases. They were in relation to the same two cases.

Senator WATT: How many entities have been investigated and found to have breached the act since the legislation has come in?

Dr Southern: I would be drawing on the figures that we have and making some assumptions about actual breaches, but I think that the 135 warning letters would certainly be indicative of breaches—and obviously the infringement notices. What I am not sure about is the 124 reinspections that I talked about—whether they related to actual infringements of the legislation. I would have to take that detail on notice.

Senator WATT: If someone is issued with a warning letter—and there have been 135 of them—it can be assumed that they have been determined to have breached the act?

Dr Southern: Yes, I think that is correct. Yes.

Senator WATT: On the 124 reinspections: what triggers a reinspection?

Dr Southern: I think that would be—and my colleagues can correct me if I am wrong here—if there had been a warning letter issued. The reinspection would occur after that to ensure that they were now compliant.

Senator WATT: So the process is that a complaint is made; it is investigated; if it is found to breach the act, a warning letter is issued—

Dr Southern: Correct.

Senator WATT: and a reinspection occurs as a matter of course? Is that a check-up to see whether the infringement has been corrected?

Dr Southern: Looking at the numbers, they do not match, so it is not 135 warning letters and then 135 reinspections, although it is a very similar number, so I will just have to double-check for you what the grounds would be for not doing a reinspection in those circumstances.

Senator WATT: Yes, could you take on notice why there was not a reinspection for those 11.

Dr Southern: Yes, certainly. I would have to say that in most cases, and in compliance frameworks, people, if prompted to, become compliant quite quickly.

Senator WATT: On those 135 warning letters: how many different entities were sent them? Were there 20 to one entity? I use the word 'entity' because it can capture retailers, tobacco manufacturers—a wide range of people. How many different entities are we talking about?

Dr Southern: I think again I would have to take that on notice.

Senator WATT: Is it reasonable to assume that in some cases there is a particular entity who might be getting multiple warning letters?

Dr Southern: That is possible, and over that period of time that is certainly a possibility, given that we are talking about the period from 1 December 2012.

Senator WATT: Does anyone at the table know whether any entity has received more than one warning letter?

Dr Southern: No. We would have to take that on notice. I just make the point again that the compliance activity is done on our behalf by the National Measurement Institute.

Senator WATT: They undertake the compliance work?

Dr Southern: They undertake the compliance work on our behalf, yes.

Senator WATT: So you receive the complaint?

Dr Southern: Yes.

Senator WATT: You investigate the complaint?

Dr Southern: No, no—

Senator WATT: They do?

Dr Southern: that is done by the NMI.

Senator WATT: And then, if they are satisfied, they issue the warning letter?

Dr Southern: I think it would come back to us for issuing warning letters and things like that, but the actual site inspections and the on-the-ground compliance activity are done on—

Senator WATT: Okay. There were 135 warning letters, four infringement notices and only one fine, so there were 134 breaches of the act without fines being imposed?

Dr Southern: Yes. As I was saying, in response to the warning letters, those entities become compliant.

Senator WATT: Would it be fair then to say that the department's approach to enforcement here is to rectify the mistake in a conciliatory manner?

Dr Southern: Yes, to encourage people to become compliant. That is correct.

Senator WATT: Can I ask about a specific example. In July last year, Imperial Tobacco was caught inserting soft packs inside its packets of Peter Stuyvesant cigarettes. I think the way that worked is that the soft packs could be removed. The Department of Health said it was investigating. I gather that happened about six months ago. What has happened since then?

Dr Southern: On that particular case, the department engaged with the manufacturer through correspondence, and basically the company undertook to remove the product from the market.

Senator WATT: Did Imperial Tobacco in this instance receive a warning letter?

Dr Southern: I do not believe it was technically a warning letter; I think it was an exchange of correspondence with them. Mr Masri, is that correct?

Mr Masri: I am just checking.

Dr Southern: My understanding is that we had an exchange of correspondence with them in relation to the inner foil packs.

Senator WATT: Is it normal that there is an exchange of correspondence with someone who has breached the act before a warning letter is issued?

Dr Southern: I do not know. I know some of the details of this particular case, but it was one where clearly we believed it was circumventing the plain-packaging legislation, so we undertook to deal with the organisation to get it compliant.

Senator WATT: Are you aware of any other instance where an entity that has breached the act has been sent correspondence or there has been some correspondence prior to receiving a warning letter?

Dr Southern: I will take that on notice and take on notice whether one of these letters was a warning letter.

Senator WATT: When you are coming back to me about the 135 warning letters, can you perhaps also break that down into the type of entity—manufacturers, retailers and whatever the other generic types of entities are?

Dr Southern: Certainly, yes.

Senator WATT: It sounds like there is also another step in the chain. A complaint is made. Investigation occurs. At least in some cases, there is an exchange of correspondence before a warning letter is sent, which might then lead to an infringement notice, which might then lead to a fine. Is that the chain?

Dr Southern: Yes, that is the way that it is set out in the legislation. You have a kind of escalating set of arrangements.

Senator WATT: Just to recap: in this instance, there was an exchange of correspondence; they made an undertaking, and that is the end of the matter?

Dr Southern: And monitoring, basically, that their undertaking has been met.

Senator WATT: So we have one of the biggest tobacco manufacturers in the world quite deliberately circumventing these laws, and nothing happens apart from an undertaking, and that is after several steps in the chain?

Dr Southern: Well, the undertaking is to remove it from the market, which is ultimately what we were seeking to achieve.

Senator WATT: Is there any point in having these fines if they are not issued?

Dr Southern: Absolutely. There is value in having the fines. But I think the way that the legislation is crafted is a process of escalation.

Senator WATT: What are the department doing to detect products which do not comply with the act? Do you solely rely on complaints from the public?

Dr Southern: No. The National Measurement Institute, which, as I said, does our compliance work for us, conducts site visits to have a look at what is going on. So, no, it is not just on the basis of complaints.

Senator WATT: Thank you.

Senator LEYONHJELM: I have about four or five subjects I want to ask you about. One of them I will kick off with because you have just been talking about plain packaging. I will start with that one. It is interesting that the single prosecution under the plain-packaging legislation relates to cigars, because that is the subject of my question. The explanatory memorandum for the Tobacco Plain Packaging Act mentioned that plain packaging is meant to 'reduce the attractiveness and appeal of tobacco products', particularly for young people. It notes research by Hammond and others indicating that tobacco packaging primarily appealed to youth and young adults. I am wondering whether you have given any thought to whether that is applicable to the cigar market and how relevant that is to the cigar market? Have you looked at that at all? Do you have any views as to whether or not that is an appropriate objective for the cigar market as opposed to the cigarette market?

Dr Southern: Yes, one particular focus is to make tobacco products unattractive to young people, and I understand there is research which does talk about the attractiveness of the cigar products as opposed to cigarettes to young people and that they are less attractive. Overall, the objective of plain packaging and the graphic health warnings is to reduce smoking right across the population, not just young people. In that circumstance, I believe that the way the legislation was put together and the original plain packaging measures were put together was to reach out more broadly so you would not segment the market and exclude some tobacco products and not others.

Senator LEYONHJELM: The argument that I have heard regularly is that cigar smokers are not young people, that they are most predominantly men and that they are probably closer to my age than young people. Is there any research—and you used the word 'research' in your earlier answer—that would indicate that the consumers of cigars are influenced by plain packaging?

Dr Southern: I would need to take that one on notice. When I was talking about research in my earlier answer, I was thinking back to work that had informed the original government position to introduce plain packaging. I was not around at the time, so I would have to go back and check that, and take on notice your request around whether there is any research that goes to the issue that you have just spoken of.

Senator LEYONHJELM: The reason I draw this to your attention is because, amongst other things, the UK has decided that the criteria are different for cigarettes and cigars,

consumers are different and factors that determine consumption are different, and as a consequence cigars are not included in plain packaging in the UK.

Dr Southern: Yes, that is correct.

Senator DI NATALE: Just ask Joe Hockey and Mathias Cormann.

Senator LEYONHJELM: Yes. I smoke them myself. I am wondering what the foundation for the policy is that they get treated the same. Take that on notice by all means. I want to ask you now about e-cigarettes. At previous estimates, the department said that a review of e-cigarettes was scheduled to be considered by health ministers in early 2017. What if anything has been put to health ministers and are there any outcomes?

Dr Southern: No, that has not gone to health ministers yet.

Senator LEYONHJELM: What is the timetable there?

Dr Southern: We are still looking at putting it to health ministers. I have early to mid 2017 here; but in the next little while.

Senator LEYONHJELM: Okay, sometime between now and the end of June, presumably.

Dr Southern: That is correct. They have not met this year yet.

Senator LEYONHJELM: They have not met yet? Okay. I have written to the health minister suggesting e-cigarettes with nicotine concentrations no greater than the European standard be excluded from the poison standards. Given that cigarettes are out of the realm of the TGA, would it be consistent to also exclude e-cigarettes from the realm of the TGA?

Mr Bowles: I think that is something we probably should check with the TGA. The issue is slightly different to cigarettes in the context of poison.

Senator LEYONHJELM: Yes, I know. I knew you would say that. It gives you another opportunity to kick it along. I cannot envisage the TGA saying: 'Oh, no, we wouldn't be interested in them. Take them out so that we don't regulate them.' I suppose it is potentially a policy decision.

Mr Bowles: Yes. Nicotine is actually a poison.

Senator LEYONHJELM: Yes, indeed.

Mr Bowles: So you have that sort of context to worry about. That is why TGA would be interested in it.

Senator LEYONHJELM: Yes, all right, but nicotine is in tobacco, too, and it is not regulated by the TGA—

Mr Bowles: Not in the same form.

Senator LEYONHJELM: and that is the reason behind that.

Mr Bowles: It is a different form in e-cigarettes, and that will no doubt come into the thinking.

Senator LEYONHJELM: In December, I wrote to Dr Skerritt, the deputy secretary of the health department containing the TGA, about e-cigarettes. I asked him what regulatory steps would be required if e-cigarettes were to be made available. He said this would largely be a matter for state and territory law. Beyond excluding e-cigarettes from the poisons

standard, are there any changes to Commonwealth law that would be required, or would it be enough in Commonwealth terms to leave it entirely to the states and territories.

Dr Southern: The split between the Commonwealth and the states in relation to e-cigarettes is, as Dr Skerritt acknowledged, a shared responsibility. The states and territories have similar responsibilities in relation to cigarettes, as well. There isn't any current Commonwealth legislation which goes beyond the TGA aspects in relation to e-cigarettes at the moment.

Senator LEYONHJELM: So that would be all that was required at the federal level.

Mr Bowles: We have TGA after dinner this evening, so you can have a talk then.

Senator LEYONHJELM: The problem is that there are a lot of things on after dinner. I will endeavour to get back to talk to them. I want to ask about medical marijuana.

Mr Bowles: That will be TGA.

Senator LEYONHJELM: Just TGA? There is a regulatory issue here.

Mr Bowles: Which is the TGA function.

Senator LEYONHJELM: Is the Therapeutic Goods and Other Legislation Amendment (Narcotic Drugs) Regulation just TGA?

Mr Bowles: TGA is the best place to talk about how that is all happening.

Senator LEYONHJELM: All right. It is just that there is a provision in that regulation which requires people seeking a licence to cultivate, research or import medical marijuana to disclose all their prior convictions, rather than just convictions for the last 10 years. That is unusual. That sort of provision is only generally applied to law enforcement recruitment. Is TGA the right person to explain why that is the case?

Mr Bowles: Yes.

[17:42]

CHAIR: As per our previous arrangement, we are going to skip briefly to program 2.7 Hospital services, for the purposes of Senator Urquhart's brief bracket of questions. Then we will return to program 2.4. We will go to hospital services.

Senator URQUHART: Thank you to the committee, the secretariat and the department for your indulgence. I have a few questions on the Mersey Community Hospital in Latrobe in north-west Tasmania. The funding for that hospital expires in June. What is the current state of negotiations for a new agreement?

Mr Bowles: Technically, the funding does not expire in that sort of way. The agreement comes to an end in June. There is funding in the out years to the tune of \$60 million a year.

Senator URQUHART: So what is the current state of negotiations?

Mr Bowles: That is in discussions at departmental and ministerial and government levels, if you like.

Senator URQUHART: So the same as this time last year.

Mr Bowles: Yes.

Senator URQUHART: When do you expect a resolution of those discussions?

Mr Bowles: Hopefully, pretty soon.

Senator URQUHART: Days? Weeks?

Mr Bowles: I would not say days. It is probably in the next couple of months—before we get to 30 June, obviously is the desired outcome.

Senator URQUHART: That is the desired outcome, obviously, but I am trying to work out a time frame of when you expect that you will have—

Mr Bowles: They are matters for both the Tasmanian and the Australian governments, so we are caught in the middle of that a little bit. As you would know, that has played out in the media a bit.

Senator URQUHART: It has. I think that if I went back to the transcript of my questions last year I would find that the answers would be very, very similar.

Mr Bowles: They would be very similar.

Senator URQUHART: Almost identical.

Mr Bowles: Yes.

Senator URQUHART: The next couple of months. Soon. I heard that 12 months ago. You are still not any closer to—

Mr Bowles: It has not been resolved.

Senator URQUHART: I know it has not been resolved, but you are still no closer to being able to give an actual time frame.

Mr Bowles: No. They are matters for government.

Senator Nash: If it assists, I understand that the minister met with Premier Hodgman and Minister Ferguson earlier this week, I think.

Senator URQUHART: Yes. I have some questions around that?

Senator Nash: I think there is a very real commitment that it needs to be resolved.

Senator URQUHART: The negotiations began in May 2016. Why are they taking so long? What has been the hold up?

Mr Bowles: At the end of the day, this is about the transfer of ownership. There is a whole range of, again, not to go back to—

Senator URQUHART: Transfer of ownership? Can you elaborate on that.

Mr Bowles: The ownership sits with the Commonwealth, at the moment. It is not a normal thing for a hospital to be in the ownership of the Commonwealth.

Senator URQUHART: No, that is right. I think we are unique.

Mr Bowles: There are a whole range of issues tied up in that that are quite complex, that will need to be sorted out.

Senator URQUHART: Have the Tasmanian government or other stakeholders made representations to the Commonwealth on the impact of the uncertainty on, for example, workers. I think I raised last year the issue of the workers having a lot of insecurity about the future for them, because they are not really clear on what is happening. Obviously, there are a lot of discussions happening, but there are not a lot of reports going back to the workforce, which is very unsettling, not just for the workforce but also for the community. It is also very destructive of services and the provision of services and it is very difficult trying to get

people—doctors, allied health et cetera—to go down there. Have the Tasmanian government or other stakeholders made representations about that uncertainty?

Mr Bowles: The broader uncertainty of the arrangements—the minister has met with the Tasmanian Premier and health minister. I or any of my officials were not privy to that conversation. Clearly, they did express concerns about their side of the issues, as my minister would have expressed issues from outside.

Senator URQUHART: Does the department share those concerns about the uncertainty that is felt by not only the workforce but other people within that chain?

Mr Bowles: We have always had concern about how this would operate into the future. That is why there is money into the out years, albeit different to what is currently there.

Senator URQUHART: I understand that the Tasmanian Premier and health minister—I think you indicated that just a moment ago, Minister—met with Minister Hunt last month. Do you know whether the 10-year funding agreement was discussed in that meeting?

Senator Nash: Are you asking me?

Senator URQUHART: I do not mind. I am happy for anyone to answer.

Senator Nash: I am not aware.

Senator URQUHART: If I can get an answer, I do not mind who answers.

Mr Bowles: The 10-year funding arrangement has been in the media; I know that. I was not privy to the conversation, but I imagine it would have been.

Senator URQUHART: You do not know.

Mr Bowles: I do not know, specifically.

Senator URQUHART: Do you know, Minister?

Senator Nash: No, I do not know, sorry.

Senator URQUHART: Has the department provided any advice to the government on a 10-year funding agreement?

Mr Bowles: We have provided advice to ministers on the issues around Mersey over a long period of time.

Senator URQUHART: Specific to a 10-year agreement?

Mr Bowles: We would have provided some advice, given it was in the media and there was commentary from both the Premier and the minister.

Senator URQUHART: Has the department provided any advice to the government on returning the hospital to Tasmanian ownership?

Mr Bowles: We would have, because that has been the issue for a long time.

Senator URQUHART: I think you mentioned that earlier.

Mr Bowles: Yes.

Senator URQUHART: Has the department provided advice to the government on the issues surrounding what has also been in the media about closing both hospitals and funding a new hospital?

Mr Bowles: Not to my knowledge.

Senator URQUHART: You have not provided any advice to the government on that?

Mr Bowles: We do not run health services in Tasmania.

Senator URQUHART: No, I know you do not.

Mr Bowles: We happen to have a technical ownership issue, if you like, for Mersey, but it is actually run in the context of Tasmania. So we would not get involved in that.

CHAIR: There is a suggestion, though, to close the two hospitals, which—I have to put on record—I think is a ridiculous idea, personally.

Senator URQUHART: Mr McCormack, you have previously confirmed that there is \$62.7 million in the budget for Mersey for each year of the forward estimates. Is that still the case?

Mr Cormack: The figure I have in here is \$60.0 million, but there is \$2 million that is set aside to cover other related expenses in the course of ownership, such as insurance and workers compensation. So yes, it is \$62.7 million.

Senator URQUHART: Is that indexed at all?

Mr Cormack: In the forward estimates it is not.

Senator URQUHART: How about beyond the forward estimates?

Mr Cormack: No.

Senator URQUHART: So is this basically an ongoing appropriation of \$62.7 million per year?

Mr Cormack: That is correct.

Mr Bowles: Which, I might add, is over and above—as I understand it—the normal nationally efficient price arrangements for public hospitals across the rest of the country.

Senator URQUHART: So this financial year, 2016-17, the Mersey is funded at \$75.5 million. That is correct, is it?

Mr Cormack: That is right.

Senator URQUHART: Why is there less in the forward estimates and beyond?

Mr Cormack: Because the deal was for two years, back when that deal was done, which ends at 30 June this year.

Senator URQUHART: So you cannot tell me whether that will be a cut? Is the department planning a cut?

Mr Bowles: The forward estimates show \$62.7 million or so for the deal, and until there is resolution over the future of the hospital we cannot really confirm one way or the other.

Senator URQUHART: All right. I might come back next year and see if I can get some further answers.

Senator POLLEY: In relation to the meeting that was held in late February with the Tasmanian minister and the Premier, can you provide to us the number of times the state minister for health and whichever federal minister was in town at the time have met with the Tasmanian government. Can you give us the dates, please.

Mr Bowles: We could take it on notice, but, again, we do not manage ministers' diaries.

Senator POLLEY: No, but you would have provided advice around those times—

Mr Bowles: We may or may not have.

Senator POLLEY: Could you take that on notice.

Mr Bowles: There are a whole range of ways ministers talk to each other. We are not necessarily privy to all of those. We will take it on notice and give you a qualified answer for what we know.

Senator POLLEY: Just to reaffirm what the Chair alluded to—that Senator Lambie has suggested closing down two other hospitals or privatising part of the Mersey—that is not something that you have advised the government on?

Mr Bowles: I have already stated that.

Senator POLLEY: Good. Thank you.

CHAIR: That will wrap up program 2.7 for now, and I want to thank the officers for reaffirming the government's commitment to resolving this issue on behalf of Tasmania. We will now come back to program 2.4.

Senator DI NATALE: Has the department done any work in terms of a comprehensive obesity strategy?

Dr Southern: No.

Senator DI NATALE: Is there anything even vaguely in this space that fits in with what would be regarded as an obesity strategy, or that might feed into it?

Dr Southern: We are just finalising the National Strategic Framework for Chronic Conditions, of which a substantial part goes to preventive health measures and risk factors that lead to chronic conditions, and of course overweight and obesity is one of those.

Senator DI NATALE: But you consider obesity to be a risk factor, rather than a specific disease?

Dr Southern: We talk about it in the framework as a risk factor, yes.

Senator DI NATALE: Are you aware of the debate in the literature around that specific issue?

Dr Southern: Yes.

Mr Bowles: I would just add that the AHMAC and the COAG Health Council have discussed this issue. It is an ongoing issue before AHMAC at the moment.

Senator DI NATALE: Yes. But at the moment there is no obesity strategy at a departmental level?

Mr Bowles: Other than our input into the AHMAC conversation, which is between the states, territories and the Commonwealth, obviously.

Senator DI NATALE: Is the department aware of the current debate on a tax on sugar-sweetened beverages?

Mr Bowles: Yes, we had this conversation somewhere earlier.

Senator DI NATALE: I asked the Chief Medical Officer about that—

Mr Bowles: That is right, you did too.

Senator DI NATALE: Are you aware of the debate around sugar-sweetened beverages?

Mr Bowles: I have seen that in the media, yes.

Senator DI NATALE: Have you seen the literature? Has the department done any work examining the literature on sugar-sweetened beverages?

Mr Bowles: Not specifically. The Chief Medical Officer said earlier today that he had been aware of the broader stuff—

Senator DI NATALE: I know, yes. I have asked the Chief Medical Officer. I am now asking whether anyone in the department has done any work on this?

Mr Bowles: No.

Senator DI NATALE: No?

Mr Bowles: Again, we would not necessarily work on a tax measure. That is—

Senator DI NATALE: But you would provide advice to the—

Mr Bowles: We would have an associated look at it, but we would not provide advice on a tax measure.

Senator DI NATALE: I cannot imagine that the ATO would look at imposing a measure like this without discussion with you. Surely, it would be a joint project?

Mr Bowles: Well, they are not.

Senator DI NATALE: They are not. Okay. But, gosh, that would be alarming if that were the case!

Mr Bowles: Yes.

Senator DI NATALE: Are you aware of any expert advice about how we respond to the obesity strategy, particularly with regard to advice to individuals recommending that halfway through a meal people put both hands on the table and just push back?

Mr Bowles: I do not think I will go there! That is media commentary—

Senator DI NATALE: I am not making commentary. No, I am asking—

Mr Bowles: Maybe the minister might want to comment.

Senator DI NATALE: I am asking about specific advice when it comes to obesity, whether you think it is appropriate that the advice provided is that halfway through a meal to put both hands on the table and just push back, and that will help you to lose weight.

Mr Bowles: Well, I do not—

Senator Nash: Sorry, just to clarify: can I ask which advice you are referring to? Who gave the advice?

Senator DI NATALE: I am asking about the advice and whether you think the advice is appropriate.

Senator Nash: No. I am just trying to determine who has given the advice?

Senator DI NATALE: I am surprised you do not recognise that comment?

Senator Nash: I do, but not in the context of advice.

Senator DI NATALE: The advice provided by previous Senator Barnaby Joyce, now Deputy Prime Minister, was, 'Get yourself a robust chair and a heavy table, and halfway through the meal put both hands on the table and just push back.'

Senator Nash: Good. I think you could have clarified that at the beginning, that you were not talking about advice from another source. You were talking about a specific comment. That is his view.

Senator DI NATALE: I am asking about the appropriateness of that view by the Deputy Prime Minister of the country in response to obesity.

Senator Nash: Can I clarify that? I think there is probably no doubt in people's minds across the country that the Deputy Prime Minister does use colourful language. I do not think I would be verballing him if I were to say that his view is that appropriate intake of calories can help control weight. I think that is probably what his intent was—without wanting to verbal him. I think that is what he was saying.

Senator DI NATALE: I think most people would get that.

Senator Nash: I think so.

Senator DI NATALE: I think that most people get that. But if I were to give that advice as a doctor I would be up before the medical board.

Senator Nash: It is interesting, actually. Dr Steve Hambleton, who you would know very well, is an eminent figure. He often refers to the ELF diet—eat less food. I think there are probably various ways of categorising that it is important for people to have the right intake of calories and expenditure of energy to lead a healthy lifestyle.

Senator DI NATALE: Do you think it is appropriate for the Deputy Prime Minister of the country to be saying that when we are facing an obesity crisis?

Senator Nash: I think you are making a bit of a mountain out of a molehill, Senator. I think what he was—

Mr Bowles: It's the other way round!

Senator Nash: True, exactly! Indeed. I think you may be making a bit of an issue of something that probably is not one. He was merely making the point, as I said, that it is about calorie intake and having a balanced intake.

Senator DI NATALE: As I said, if I were to give that advice to patients I would probably be before the medical board. What is the government doing specifically to address increasing rates of obesity in Australia?

Dr Southern: There is a range of programs and measures which are administered by the department. There is the health star rating system on packaged and processed foods, which is about helping people to make healthier choices when choosing across a particular product line in a supermarket. One of the outcomes of the health star rating system is that some food companies have chosen to reformulate their foods to make them healthier and get a higher star rating. Minister Gillespie chairs the Healthy Food Partnership, which is a partnership between government, food industry representatives and public health experts particularly looking at doing particular streams of work around food reformulation, around portion size and around communications to the broader public about healthy eating. That work is underway. There are the national dietary guidelines which exist. The healthy weight guide is a website maintained by the health department, which includes steps and tools to encourage physical activity and healthy eating to maintain a healthy weight.

Senator DI NATALE: I have some questions on the cancer screening program, so I will move onto another area if that is okay. Can you outline when the cancer screening register will come into place?

Mr Bowles: The revised date is 1 December.

Senator DI NATALE: This is an issue I recall quite well because it was the subject of a Senate inquiry last year. Although the government was not keen to have one, we pushed to have a Senate inquiry. There was a rush to get this bill introduced. It certainly proceeded very rapidly through the parliament. We were informed that any delay last year would cause chaos because of the implications on the pathology workforce. The workforce would shrink from May 1 in preparation for these changes, meaning that there would not be enough people to read the results. We were told in no uncertain terms through a number of briefings that it was absolutely critical that this legislation pass by the date that was proposed by the government, and if not there would be chaos. We are now looking at December—a significant delay. Are we seeing the chaos the government warned of within the sector?

Mr Bowles: If you followed it in the media we have had a number of conversations around the workforce and we have put a number of measures in place to deal with the workforce issues to get us to 1 December. There was, as you rightly point out—

Senator DI NATALE: What is the nature of the workplace issues?

Mr Bowles: I will get Professor Murphy to give some detail on this. Just to highlight it, this was always a difficult project, as you identified.

Senator DI NATALE: The government identified it.

Mr Bowles: There were a number of issues in delay and going to committee and getting all these things. That did put some pressure on. Data from the states and territories is also, obviously, something that we have to manage. All of those things came together to mean that we cannot meet the 1 May date, and that is why 1 December is there. To deal with the workforce, Professor Murphy had a series of conversations with pathology groups and practitioners to come up with ways of dealing with the workforce pressures.

Senator DI NATALE: Can I just correct or clarify something? The legislation was passed by the government deadline.

Mr Bowles: Yes.

Senator DI NATALE: The government set a deadline and the deadline was met. We were told that if the deadline was met we would have this up by May 1. So please do not suggest that it has anything to do with an inquiry.

Mr Bowles: I am not suggesting that at all.

Senator DI NATALE: That was an implication in the response you gave.

Mr Bowles: I suggested that was one of the factors. We probably did not understand how significant that was—I will admit to that—and it just put us under more pressure. The more pressure we had; the more it played out into the states and territories around access to the data. That is not an issue with the states and territories; it is just a fact of life that when things get delayed that is what happens. We announced last week that there was a delay, and we worked with the pathologists in particular to work on the workforce issues.

Senator DI NATALE: Just to be clear: the deadline of 1 May that was suggested by the government was met. The legislation was passed by—

Mr Bowles: I understand that. It is part of the issues that I have to deal with in the context of this program.

Senator DI NATALE: Professor Murphy, can you perhaps outline the workforce implications?

Prof. Murphy: The issue with the pathologists was the planned downsizing of the cytology workforce, which has been looking conventionally at Pap smears because the new technology only involves viral screening and cytology for only about 20 per cent of the cases. The challenge was that they had been retraining and planning to downsize their cytology workforce, so the way we have dealt with that is that part of the new technology program is using a liquid-based cytology—a different form of cytology—which is much more automated. We have introduced a Medicare item number for that from 1 May so that the cytology workforce can do more with a smaller workforce to maintain a cytology-based screening program for those six months. We have also addressed what has been a historical under-remuneration of the conventional Pap smear payment by pushing it up to what more accurately reflects the costs of that test so that the cytology workforce can be retained, and the pathologists feel that they can now bring some of those—

Senator DI NATALE: What are the numbers we are talking about?

Prof. Murphy: The conventional Pap smear Medicare fee was \$19.45. Traditionally it is going up to \$28 on 1 May, and we have introduced a new Medicare item for liquid-based cytology—this more automated form—of \$36 from 1 May. Both of those will apply until 1 December, when the Pap smear will disappear and the liquid-based cytology will continue—

Senator DI NATALE: What is the proposed cost of those measures?

Prof. Murphy: The proposed cost of those measures is still being worked out, but it is going to be approximately \$13.5 million. But I should point out—

Senator DI NATALE: So this delay is going to cost \$13.5 million?

Prof. Murphy: No. Can I point out that the vast majority of that is introducing the new liquid-based cytology item number, which would have come in anyway from 1 May if the new technology had come in. It actually has been introduced by pathologists over the last two years, and a large number of women are paying privately for that at the moment. A significant part of that money is a transfer from private payment by women to a Medicare item to cover that. It is an increased cost to the taxpayer; there would have been an increased cost anyway with the introduction of the new technology, because it is more expensive. The advantage for women is that they will be able to have this automated technology without paying privately for it.

Senator DI NATALE: How much is the increase in the rebate for the Pap smears worth? Because that clearly would not have happened if this delay did not occur.

Prof. Murphy: That is true, because the Pap smear would have disappeared—

Senator DI NATALE: That is right.

Prof. Murphy: but it has been underfunded. The pathology group has been very concerned about it being underfunded for some years—

Senator DI NATALE: I get all that. We are talking \$28 for a Pap smear, so is really just a question of how many Pap smears will be done in that period of time at a cost of close to \$30 per Pap smear—

Prof. Murphy: The pathology workforce is currently working through—

Senator DI NATALE: not to mention all the other costs associated.

Prof. Murphy: It is probably going to be about 50 per cent liquid-based cytology and 50 per cent Pap smears over the next six months. That \$13.5 million was modelled by the medical benefits group; we can provide a breakdown. The vast majority of that money—remember that the increase in the Pap smear is just a little over \$8—

Senator DI NATALE: Yes, but those smears would not be done.

Prof. Murphy: No, not the Pap smears.

Senator DI NATALE: That is right, so it is not actually the increase in the cost of the smears; it is the total cost of the smear, which is close to \$30.

Prof. Murphy: It is \$28.

Senator DI NATALE: Yes, \$28. It is basically the number of women who are having a Pap smear over that six-month period at \$30 each. That is an additional cost—not to mention the fact that you are exposing women to an intervention that would not have been necessary had the deadline been met. What is the total cost of \$28 per smear for that six months?

Prof. Murphy: I think we built the additional cost in on the basis of the increase. We would have to take that on notice from the medical benefits division. All I know is that the modelling over the six months is about \$13.5 million. We would have to provide on notice what the breakdown is, but the majority of that is the liquid-based cytology.

Senator DI NATALE: Can you give me a list of all the consultation that took place with the various pathology representatives through this process.

Prof. Murphy: Yes. Over last Thursday, Friday and last weekend, we had a series of teleconferences with every peak pathology group, so eight people representing the major providers—Pathology Australia, Public Pathology Australia, the College of Pathologists and the major private providers. They were all involved, all represented. They were all involved in the discussions and were very collaborative. We also consulted the College of General Practitioners, the College of Obstetricians and Gynaecologists, the College of Rural and Remote Medicine, the AMA. We had a consensus view from all of those that this was a workable solution and a way to go forward.

Senator DI NATALE: I understand that. I will come back to this as I have got more questions. There is a bit of a pattern emerging of stuff-ups, delays—three years for the Life Saving Drugs Program—and now a six-month delay for something that was rushed through parliament.

Prof. Murphy: I do not accept that.

Senator GRIFF: I would like to briefly discuss the National Diabetes Strategy 2016 to 2020. Whilst the strategy itself is not too dissimilar to the 2000 to 2004 strategy, the responsibility for action seems to fall on the Australian National Diabetes Strategy implementation group. Is that correct?

Dr Southern: At this present time, yes. The next stage of the process, which was agreed by COAG health ministers, was that we form an implementation group with states and territories to work up an implementation plan for the strategy.

Senator GRIFF: How often does that group meet?

Dr Southern: It met quite a number of times. We might have to take on notice the exact number, but I think it had its most recent meeting about two weeks ago.

Senator GRIFF: If you could let me know that, that would be fantastic. How far have they actually progressed with their five key objectives in the last 12 months?

Dr Southern: The five key objectives under the actual plan?

Senator GRIFF: Yes.

Dr Southern: I guess the piece of work at the moment is actually around the implementation so it is working up the implementation plan. Once we have that plan and it is agreed through ministers, which we are hoping to do by the middle of this year, that is when the states and territories and the Commonwealth will actually go to the measures that will support the objectives of the plan.

Senator GRIFF: So this group that is the implementation working group is still working up its implementation plan?

Dr Southern: That is correct.

Dr Southern: The implementation plan working group was tasked by COAG health ministers and the Australian Health Ministers Advisory Council to actually put together the implementation plan so it could be clear which measures were going to be taken and by whom. Perhaps Mr Smith has got a bit more detail on where the implementation plan is actually up to.

Mr Smith: The implementation working group implementation plan has gone out for consultation. That is going to be out for consultation with state and territory key peak bodies and key organisations over the course of the next month.

Senator GRIFF: So that implementation working group has actually put its plan out for consultation?

Mr Smith: The implementation plan is out for consultation as of yesterday.

Senator GRIFF: So we have got a very key health issue and, if we go back and have a look at the 2000 to 2004 strategy that pretty much everyone reports was dumped—never progressed to where it was supposed to progress—and here we have a new one and it is still does not seem to be actually actioning anything at this point.

Dr Southern: The former plan that you were talking about, perhaps one of the issues around that was that it did not have an implementation plan which underpinned it and that the real purpose of the implementation plan is to operationalise each of the strategies key objectives, so working with the states and territories to look at if there are any gaps in measures that they currently have in place that are needed to operationalise the strategy.

Senator GRIFF: I kind of understand, Dr Southern. But the first objective is: 'Compile a stocktake of national and state and territory existing diabetes related activities'. I would have

thought that would be something they should be doing now—without having to put that plan out for consultation.

Dr Southern: We might be getting a bit confused here between the plan of work for the implementation plan working group and the actual implementation plan. That stocktake was one of the first pieces of work the implementation plan group did. That work has been undertaken.

Senator GRIFF: Is that something you can table or provide us with? The stocktake?

Mr Smith: We would need to take that on notice.

Senator GRIFF: I would appreciate it if you could do that. Going back to the actual strategy, it proposed to add diabetes to the Australian Commission on Safety and Quality in Health Care's Clinical Care Standards program. Has there been any progress on that?

Ms Flynn: We have been having discussions on that one. There are a couple of items included in the implementation plan—updates to guidelines and that kind of thing. So we have to talk to the relevant bodies.

Senator GRIFF: I would also like to ask about the Health Care Home trial for people with chronic disease which is about to commence. Why is diabetes monitoring not mentioned in the Health Care Homes evaluation as a performance outcome measure?

Mr Bowles: That is actually under the next outcome. Do you want to cover it here, Chair?

Senator GRIFF: I think, Chair, because it relates to diabetes, it would make sense to do it now. It will only need a very quick answer, I would have thought.

CHAIR: Will you be here for 2.5?

Senator GRIFF: I will, so we can cover it then if you prefer.

CHAIR: Let us hold it until 2.5.

Senator GRIFF: Has the department funded or piloted any population treatment programs similar to the highly effective Wellington Town Challenge in New South Wales? Some 450 residents collectively lost 1,000 kilos over 18 months—it was specifically about weight loss and diabetes.

Dr Southern: Not in recent times, I do not believe.

Ms Flynn: No, not in recent times. There was some funding under the national preventive partnership agreements which, through state and territory governments, did support such activities.

Senator GRIFF: Does the department have a plan for any more specific diabetic training that will be required over the next 10 years for educators, podiatrists and so forth? I could not see that in the documentation I have read.

Ms Flynn: From memory, there are proposals in the implementation plan to work with the health workforce.

Senator GRIFF: I have some questions on the National Cancer Screening Register. To recap: we were told last year, when there was some pressure on to pass this legislation, that it was necessary to pass the legislation—in October, I think it was—so that the register could be up and running on 1 May. You have told us that it is now going to be 1 December 2017. I was there for the inquiry. We were told by both Telstra—and, I am pretty sure, by departmental

officials—that, provided that legislation was passed in October, there would be enough time to have this up and running by 1 May. It feels a little like we were misled about that in order to exert pressure to get the legislation through.

Mr Bowles: I reject that claim. That was the view at that particular point in time. It proved, with the complexity of dealing with the states and territories, all the data requirements, and assimilating all data across all programs, not to be true. There was no desire to exert pressure to do as you described. This was simply a factor of trying to get the complexity of all the state and territory registers and how all of that comes together. For us, clearly it would have been easier if had got onto this earlier, but we did not, so it is now delayed until 1 December.

Senator WATT: In retrospect, do you regret going to an external provider?

Mr Bowles: No.

Senator WATT: My recollection is that, I think, the Department of Human Services already offered some registry-type services for bowel cancer—

Mr Bowles: They do the bowel cancer registry. That is correct.

Senator WATT: And there was another well-established provider: the Victorian Cytology Service—

Mr Bowles: Doing stuff for Pap smear testing, yes. That is a completely different set of issues.

Senator WATT: They had a register—

Mr Bowles: They had a register for the Pap smear test.

Senator WATT: but, instead, the department chose to go with a new untested external provider and now we are looking at a seven-month delay.

Mr Bowles: We chose to go with an external provider based on a robust approach to market.

Senator WATT: Do you think now that process was a bit flawed?

Mr Bowles: No, I do not.

Senator WATT: It is not flawed but it has led to a seven-month delay.

Mr Bowles: There are a range of factors, as I have said, that have led to a delay.

Senator WATT: We have heard about adding a new MBS item. Did that contribute to the delay?

Mr Bowles: No.

Senator WATT: When was the department first made aware that Telstra was not going to meet the deadline of 1 May?

Mr Bowles: Probably around Christmas time we were made aware that there was a risk. We have been working with the states, territories and all partners, including Telstra Health, to look at options, and the decision, effectively, was made last week that we were not going to make the 1 May date.

Senator WATT: When was the department first made aware of the workforce issues that were arising?

Mr Bowles: The workforce issues were always there in the context of 1 May. Once the decision was made that we could not meet the 1 May date, we had to deal with the workforce issues which we have.

Senator WATT: Has the department been asked to consider staging a staggering the introduction and the recall so that we do not have big delays resulting from a large number of tests in a small workforce?

Mr Bowles: Yes, we have looked at all options. If you run a national registry you cannot really start with bits and pieces, otherwise you lose a national registry.

Senator WATT: What would you say some of the risks are that arise for members of the public in this survey?

Mr Bowles: If we split the two issues, bowel screening continues as is. I think if you look at some of the advice we have received from places like the RACGP who have been pretty clear that having safe high-quality health care for patients is critical. The advice is that we should not rush to anything that would create problems. Both of these tests are pretty much world-leading and they are evidence based.

Senator WATT: In the department's submission to the Senate inquiry, we were told that a delay may result in a gap in screening services. What does that mean now that we are facing a delay?

Mr Bowles: We have come up with alternate ways of dealing with the screening, including continuing with the Pap smear test.

Senator WATT: Is that ThinPrep Pap Test?

Mr Bowles: No.

Senator WATT: That is something different?

Mr Bowles: I will get Professor Murphy to explain the difference. It is the new technology that was going to be introduced on 1 May. We are still going to introduce that and we will see a lot of the pathology providers use ThinPrep in the context of the current testing.

Senator WATT: Just hold that thought for a tick, Professor Murphy, and I will come to that. Returning to the department's submission to the Senate inquiry, we were also told that if there were a delay there would be no safety net for women participating in cervical screening, which risks their health and safety. Is that risk still alive?

Mr Bowles: No, it is not because we will continue the current test, which is proven.

Senator WATT: That was never a real risk of delay?

Mr Bowles: It is a risk if you do not have anything at all in place. We have moved to have a range of procedures in place.

Senator WATT: Again, we were also told that delaying the MBS items for the renewal will potentially impact participation in the National Cervical Screening Program and will have impacts on the pathology workforce. What does that mean, now that we are facing a delay?

Mr Bowles: Sorry?

Senator WATT: The submission from the department said that delaying the MBS items for the renewal will potentially impact participation in the National Cervical Screening Program and will have impacts on the pathology workforce.

Mr Bowles: We have just been over that and said we have put different mechanisms in place around the ThinPrep and the current Pap-screening arrangements that would alleviate the workforce pressures, and that is the work that Professor Murphy talked about before.

Senator WATT: Professor Murphy, I think you issued a statement on 23 February about this matter, and it referred to the complexity of assimilating and migrating data from eight state and territory cancer registers. Mr Bowles put that up as one of the reasons for the delay. But am I right that the bowel-screening data is not being assimilated and it is already in one register, so that is actually not an issue?

Prof. Murphy: Correct. The issue is very much in relation to the complexity of the cervical screening register. That is where all of the problems are. The bowel register is part of the program, but the complexity the secretary has referred to is getting all of the state and territory registers in and getting a link with all of the pathology providers and making sure that there is a safety net. What was referred to before about safety is that we could in theory have gone ahead with the new technology on 1 May, with the new Medicare items, the new viral based screening program, followed just by liquid based cytology. But, without a functioning register, that would be unsafe, because the register provides the safety net to check that women have had proper follow-up and have been called back and have had the relevant colposcopies and other tests. So it is possible to move, but the register is an important part of that safety net.

Senator WATT: Mr Bowles, returning to what we were told in the Senate inquiry, again, I am not accusing you of doing this, but I know that ministers were putting substantial pressure on the opposition and probably crossbenchers to get this legislation passed. We were told there were some really serious public health risks if this did not happen. I think we all still had some concerns about this and I think Labor put our concerns on the record, but we accepted that this was necessary to go ahead. So, again, I think we are feeling a little bit misled that getting that legislation through was not what was needed, and delays could be fixed anyway. Prior to that legislation being debated and passed, the department was not made aware of any risks around implementation on time?

Mr Bowles: I think we have already gone over that. There were risks, and at the end of the day the view in that October period was that we needed to get this moving as quickly as possible. I do not accept that we have tried to colour that in any particular way. What has proven to be the case is that the complexity around this issue has meant we cannot meet 1 May for the registry, particularly, as Professor Murphy said, around cervical screening.

Senator WATT: Professor Murphy, coming back to what you just said about the state and territory data, there already was a Commonwealth bowel cancer register operating and there still is. There was no need to get data from the states and territories to set up the bowel register, because it was already there. What is the issue around the excuse being given around state and territory data and the difficulties there getting that from the states and territories?

Mr Bowles: Cervical screening—they have their own individual registers.

Prof. Murphy: And they are all different, in various different levels of maturity. The Victorian register is probably the most mature. Other states have very immature registers. That all has to be exported, with ethical and proper processes around that, and converted into a register of a completely different purpose, not just Pap smear running, but it has a whole

complex algorithm of how people are virally screened. Depending on what virus they have, they go down different paths. They may or may not have liquid based cytology or they may go straight to colposcopy. We are one of the first countries in the world to introduce this. It is a complex process and the feeling was that without a safety net we could not go ahead.

Senator WATT: Professor Murphy, regarding your statement on 23 February, I understand that stated that delays in passing the legislation were a factor in the register not been ready. We have already talked about the fact that the Senate was told the legislation had to be passed by 30 October, and it was passed. There was no impact from the legislation?

Mr Bowles: I am probably best to answer that. Effectively, it is a hindsight comment. It is now 1 March and at that particular point in time we thought we could make the deadline. It was passed. I accept what was said at the particular point in time. The fact remains that we could not meet that date now.

Senator WATT: I understand. But my question—

CHAIR: We will return to this topic, but the committee will now suspend for a one-hour break.

Proceedings suspended from 18:30 to 19:32

CHAIR: We will reconvene. Senator Watt, carry on with your questions for no more than 10 minutes, and then we will move on.

Senator WATT: Can we go back to the cancer screening register? I want to recap to make sure I have straight the evidence we got before the break. Some of this came from responses to Senator Di Natale. When the legislation was passed in October last year, we were told in the Senate inquiry that it was essential that it be passed then so that we could have a 1 May operation date. That has now blown out to 1 December this year. Are you confident that can be met?

Mr Bowles: That is the arrangement we have in place.

Senator WATT: That is about as high as you can put it?

Mr Bowles: We are pretty confident we can get there, but, as I said, this is a complex set of issues. In relation to your comments about October, to recap on what I said: hindsight is a wonderful thing. It was too tight to meet with all of the complexities that we have to deal with.

Senator WATT: You told us before the break that the department was first made aware before Christmas that the 1 May deadline would not be met.

Mr Bowles: I said there was concern about meeting the deadline around Christmas time. We had a range of conversations since then which led to decisions that were made, I think, last week. They are blurring at the moment.

Senator WATT: When you say around or before Christmas time, did Telstra advise you of concerns they had? Is that how you became aware of the delays?

Mr Bowles: Between Telstra and us talking about what is possible and feasible, yes.

Senator WATT: Could you narrow that down a little bit more than before or around Christmas?

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

Senator WATT: Okay. Is there anyone here who knows?

Mr Bowles: No.

Senator WATT: So no-one here has been in direct contact with Telstra and directly handling it?

Mr Bowles: I have been talking to Telstra regularly, but I do not have that specific date. I said around Christmas time. It was probably just before Christmas, obviously.

Senator WATT: Okay. And it was made public last week?

Mr Bowles: Last week we firmed up the decision that we could not meet the dates, which meant we had to firm up and try and sort out what the new date was, which was 1 December. There were subsequent discussions around the workforce issues which we had talked about earlier.

Senator WATT: Why didn't you think it was necessary to inform women and GPs earlier of a delay—before Christmas, when you first became aware of this risk—to the delivery of a test which is going to pick up cervical cancer? Why didn't you think that was necessary?

Mr Bowles: I do not think that is exactly what I have said. We had concerns around that time, and we were working to continue to see what we could do to mitigate some of the issues. It became apparent, hence the decision last week, and, as soon as we did that, the Chief Medical Officer put a statement up on the web. As you mentioned, I think it was 23 February.

Senator WATT: So nearly two months elapsed between the department being first made aware there were risks and the public being told?

Mr Bowles: Well, we had to work through it. The decision about what was doable and not doable was not made until last week.

Senator WATT: We also talked a little bit about some of the interim solutions that have been put forward, and I think there has been an additional MBS number.

Mr Bowles: The new liquid-cytology item was always going to come in on 1 May, but we have continued with that because it actually deals with some of the workforce issues as well.

Senator WATT: Can we go through, item by item, the interim solutions that have been put forward to deal with this delay. Can you take me through each one of those and what the expected cost is going to be.

Mr Bowles: We have done this before.

Senator WATT: Yes. I just want to capture it concisely.

Mr Bowles: Professor Murphy can take us through what he did with Senator Di Natale before, but it is not going to change.

Senator WATT: Just briefly—just the two or three highlights.

Prof. Murphy: The key item is the availability on 1 May of the liquid-based cytology item, which means that, although from May until December, screening will still all be on cytology, we can access this new form of cytology. This new form of cytology is much more automated and can ensure that, with the reduced workforce, the pathology labs can buy a mixture of conventional Pap smear for about 50 per cent of the work and the new liquid-based cytology for about 50 per cent. They will be able to meet traditional cytology-based screening under the old regiment until the new technology comes in in December.

Senator WATT: And what did you say the cost to government is likely to be?

Prof. Murphy: Of those Medicare items, about \$13.5 million, but that is still being worked up because the modelling has to be fully done with the volume—it is about \$13.5 million.

Senator WATT: Given that this is being put forward as part of an interim solution, is that likely to then be an ongoing cost?

Prof. Murphy: No, the ongoing cost will be the cost of the new technology, which is in two bits. One of it is the liquid-based cytology, but that is only for 20 per cent of the screening. The other 80 per cent will be done by this new viral test, which is done on the same sample from that cervical area, and that is a test which looks for the human papilloma virus. Only those people who have a certain virus detected will then go on to cytology. The unit cost ongoing of those two tests will be higher. The liquid-based cytology will be at least \$36 and the viral test will also be high, so there will be an increased unit cost for screening but, over the long term, because screening in the new system will only be done every five years, the cost to the taxpayer over time will be cost neutral.

Senator WATT: Was the ThinPrep test always going to be available on 1 May?

Prof. Murphy: That was the intention because it is an integral part of the new technology for the 20 per cent of people who the viral tests suggest need it. What we are doing now is using it for the 50 per cent of people who have cytology screening just for the interim period. But, after 1 December, it will only be needed for 20 per cent of people.

Senator WATT: Does that explain why your statement says it will only be available until 1 December?

Mr Bowles: The full costing of the liquid-based cytology has not been completed, so from 1 December there will be this item but it will probably have a different value to it.

Senator WATT: Are there any other any other costs that are going to be incurred as a result of the interim solution? Are there going to be more payments to DHS to continue the bowel screening register or payments to the states to keep their registers operating?

Mr Bowles: We will not be paying the states. The states will continue with their processes, but we will continue to pay DHS.

Senator WATT: Can you quantify what that cost is likely to be?

Mr Bowles: No, I cannot at this stage.

Senator WATT: Are there any other costs associated with the interim solution?

Prof. Murphy: I think we have also made some up-front provision to the pathologists to try and retain the workforce, so we are working out with them at the moment an allocation of a small amount of up-front cash to help them retain their workforce.

Senator WATT: Are we talking millions or thousands of dollars? What is that likely to be?

Mr Bowles: I think we are talking around \$3 million.

Senator DI NATALE: Is that part of the \$13.5 million?

Senator WATT: That is in addition, I assume?

Mr Bowles: It would be in addition, I think. We do not know the full costs yet, because we have not actually done all the volume-based modelling, so in the interim let's say \$16 million to \$16.5 million.

Senator WATT: Plus whatever costs you are going to have that DHS will incur to keep running its register.

Mr Bowles: Yes.

Senator WATT: Nothing else?

Mr Bowles: Not that I am aware of.

Senator WATT: In terms of the ThinPrep test—sorry, this might be the same question asked in another way—is it only going to remain until 1 December?

Prof. Murphy: The ThinPrep will continue from 1 December as part of the new technology but in a much smaller volume and probably with a different price. This technology is part of the new generation screening, but it is only for those for whom the viral test suggest it is necessary.

Senator WATT: There were no plans to add ThinPrep as an MBS item until this delay?

Prof. Murphy: No, it was always going to come in on 1 May as part of the new technology. What we have done is said we will bring it in anyway, and we will set a quick price for it to give the pathologists some certainty, but the formal price for it will be determined by the costing work that is still underway. It will continue from 1 December.

Senator WATT: Thank you.

Senator DI NATALE: I am going to ask some more questions on this. You can appreciate that there was obviously a lot of effort that went into us getting this over the line. One of the concerns we had at the time was the contract with Telstra—was it \$220 million?

Mr Bowles: I think that is roughly the figure.

Senator DI NATALE: We had concerns about that at the time. We were told how critical it was to get this done by that deadline so we could have it in place from 1 May. To be clear about the cause of the delay, I have not actually got an explanation about why it has taken so long.

Mr Bowles: It is a complex issue.

Senator DI NATALE: No, no, no. We have heard that about 15 times on so many different areas.

Mr Bowles: Well, I am afraid—

Senator DI NATALE: No, we have heard that. Talk me through the details.

Mr Bowles: If you would let me, I will talk you through the issues. I cannot move away from the fact that health is a complex space. It is a complex space. This is a complex project. If we just focus on the cervical screening, not the bowel at the moment, the bowel has its current register, so it will continue in its current form with effectively no change. In the cervical, it is about pulling together the states' and territories' current registers, which, as Professor Murphy said earlier, are not all the same. They obviously have the same intent and ultimate outcomes, but it is about pulling them all together for the new HPV testing. That is really the big issue.

Senator DI NATALE: Are the states holding on to it? Is that the problem? Are the states holding on to the information?

Mr Bowles: No.

Senator DI NATALE: So Telstra has the information and it is just proving to be a more difficult technical project?

Mr Bowles: You have to get the data and make sure it is clean, if you like—in technical IT language. You then have to configure it in such a way that it actually meets the needs of the program. Then you have to make sure you have all of the clinical call-back issues in place that these registers need so people do not miss the follow-up testing and things like that.

Senator DI NATALE: I am trying to get to the nature of the delays because of the technical nature: Telstra has all the information; it is trying to ensure that all the specifications outlined in the brief are met, and it has not been able to do it within the time frame because it is more difficult than what they anticipated?

Mr Bowles: Again, it gets back to: in October we thought, if it was done by then, we could get things in place. Hindsight is wonderful, but we did not.

Senator DI NATALE: But Telstra gave the deadline?

Mr Bowles: No. The deadline started off as the introduction of HPV for 1 May, and Telstra said at that point they could deliver 1 May.

Senator DI NATALE: Which they have not been able to do.

Mr Bowles: Which they have not been able to do based on a whole range of factors—

Senator DI NATALE: Telstra said to you—and I know, because we had briefing after briefing—they had a lot of pressure from the department; they had a lot of pressure from the government. We wanted to wait. We kept hearing how critical it was, and we were told at the time that Telstra said that this legislation had to be passed by—

Mr Bowles: The 13th October or something—no, the 30th.

Senator DI NATALE: Telstra gave the deadline. They said before the 30 October deadline in order for it to be done by 1 May.

Mr Bowles: Yes.

Senator DI NATALE: So the problem here is that Telstra, who were the ones who set that deadline, have been unable to meet the deadline because it has been more difficult than they anticipated.

Mr Bowles: More difficult. Nobody really understood the complexity of the states and territories data requirements. We could not actually start to get the data off the states and territories until the legislation was passed. I think everyone at that point in time believed that we could still meet the 1 May for the HPV testing. Once you cannot meet the register, you cannot run the test in the same way.

Senator DI NATALE: Yes, I accept that. Again, I am just trying to get to why we have had a delay here.

Mr Bowles: I cannot explain it any other way.

Senator DI NATALE: The contract was signed with Telstra before the legislation was passed. Is that correct?

Mr Bowles: Yes.

Senator DI NATALE: The \$220 million contract was signed with Telstra before the legislation was passed. So, obviously, there was an imperative to get the legislation through, because you had already signed the deal with Telstra. Did Telstra—

Senator Nash: Senator, can I just say on that, because I think we are going round in circles here—

Senator DI NATALE: No, I am actually—

Senator Nash: It was just on that point—

Senator DI NATALE: As long as this does not eat into my time.

Senator Nash: It will take 10 seconds. I think there was an expectation that this was not going to be controversial, that everybody recognised the importance of this. I just think we need to factor that in. That is all the time I will take. Thank you, Senator.

Senator DI NATALE: Sure, but it proved to be controversial because we have missed a deadline. It is costing a lot of money and people are having unnecessary—

Senator Nash: I am not going to take up your time, but I am just making the point that at the time we would have thought that it wouldn't have been controversial.

Senator DI NATALE: Clearly, it was, and it has proven to be. The fact that we are having this conversation shows it was controversial and we were right to be cautious about it.

Senator Nash: No!

Mr Bowles: Senator, you are focusing on one party to this. There are multiple parties.

Senator DI NATALE: I accept that, but I want to understand why we had the delay. You signed the contract with Telstra for \$220 million before the legislation was passed. Were there any penalty clauses in the contract?

Mr Bowles: There would be the normal arrangement in contracts for penalties depending on what the issues at stake were, yes.

Senator DI NATALE: We know there were penalty clauses because we were told during the briefings.

Mr Bowles: Yes, and that is what I just said.

Senator DI NATALE: Yes. So the penalty clauses in the contract were that, if this is not met by this particular deadline of 30 October—and if you have not got it in front of you, can you take on notice the nature of the penalty clauses in terms of—

Mr Bowles: We can take that on notice.

Senator DI NATALE: So there were penalty clauses that said if the legislation was not passed by 30 October then Telstra would be awarded some compensation for that. Were there any penalty clauses for Telstra not meeting their deadline?

Mr Bowles: There would be, depending on the circumstances of which the deadline was missed. As I have taken you through the complexity of bringing all of these eight registers together, that were all different in some way or form, changing to a new testing regime—

Senator DI NATALE: All of which we knew beforehand.

Mr Bowles: All of which we knew; however, the difficulty of that proved, in hindsight, that we did not and could not meet 1 May, and that is the reason. We have regular discussions with Telstra, as we have regular discussions with the states and territories and the Department of Human Services, who also have data. We have to match this data. It has to be accurate. We have to get all of these things working together in a registry sense. That has been the complexity that we have been dealing with.

Senator DI NATALE: Those registers already exist, so of course we understand the complexity. We have set a timetable for this. The question I have is: had this not been awarded to Telstra and been kept within the existing department, it is still done as a national register, which is what—

Mr Bowles: I do not accept that at this point. Different states and territories were running their own registers. I think we have already determined that Victoria was a little bit more advanced from a register perspective than a number of other states. But what we were talking about, with the introduction of the HPV testing, was the requirement to move to the national register, and that is where the complexity came into it, and I do not believe that whoever was running this would have been able to do much different. That is a theoretical question, because we really do not know.

Senator DI NATALE: So, are you saying that it is partly the department's fault, partly Telstra's fault—or it is entirely the department's fault?

Mr Bowles: I have already accepted that it has to be partly the department's issue, because we are part and party, Telstra is part and party, the states and territories are part and party. We are all in this together to work out how we can run a safe, clinically appropriate registry for this issue.

Senator DI NATALE: Again, I come back to that point about Telstra having a particular deadline saying that it needed to be achieved by 1 May. I just want to be clear about whether they played a role in these delays.

Mr Bowles: I cannot say it any other way: we are all part and party to the outcome that we actually have today.

Senator DI NATALE: Let me come back to the rebate for the cytology test—the ThinPrep Pap test. That is at \$36, but you expect that to come down?

Prof. Murphy: No, I expect it to be at least as high as that, because it is a more expensive test. The pathologists were claiming that it costs about \$35, but we do not have the data. There is a formal costing study happening, which is due to report in a few weeks. It was going to report to set the formal tests on 1 May, but we had to set a test value now to get the pathologists to model and be happy that they could meet the workforce needs of the future. So, this is a temporary value for that test. It also reflects that they will be doing a lot more volume of that test in the next few months and they will do from 1 December. After 1 December only 20 per cent of the screening will have the liquid based test.

Senator DI NATALE: That is because you do the HPV as a first screen—

Prof. Murphy: As a first screening test, yes.

Senator DI NATALE: And most people do not need a subsequent—

Prof. Murphy: Correct. So, this is an interim measure. There will be a formal, properly modelled cost, and the value will be something similar to \$36 but it could be a little bit higher; we do not know, until that data has come through.

Senator DI NATALE: Can you talk me through this \$3 million?

Prof. Murphy: Part of that was because the pathologist felt that \$36 was not absolutely adequate to meet the cost of doing it, because they set the actual base cost of \$35. But rather than set a fee that was a guess, we decided to give them some up-front cash. Part of it was because many of them had to pay money to retain their workforce. For the workforce they had redeployed or who went off to take a package, they have had to pay a retention amount. And the third bit was that pathology companies had invested in the HPV technology, that kit. They often rent that kit, and that kit will not be able to be used from 1 May to 1 December, and they had planned to do that. So, they have had some rental outgoings not matched by revenue. It was a general compensation package done to get them comfortable.

Senator DI NATALE: How did you arrive at that figure? On what basis?

Prof. Murphy: It was by a series of very collaborative negotiations with the pathologists over the weekend.

Senator DI NATALE: I would be collaborating if I was looking at getting \$3 million!

Mr Bowles: It is spread across all pathology.

Prof. Murphy: The Pap smear test screening program costs nearly \$50 million to run every year through Medicare, and the new test regimen, as I said, will be more expensive on a unit cost basis than it is now. So, yes, the pathologists have had to do a lot of stuff to get their work—

Senator DI NATALE: But what was the basis for coming up with that figure?

Prof. Murphy: The basis was an analysis of what the pathologists felt was their costs—the sunk costs—in meeting the HPV technology and the cost that they thought they would have to meet to retain staff.

Senator DI NATALE: We heard during the inquiry that Telstra wanted information from Victoria Cytology about establishing the register, and they were not keen to give that up; they thought it impinged on their intellectual property. Was that a factor in the delay?

Mr Bowles: I could not definitively say that at this particular point. I do not believe that to be the case, but I think that will be an issue that I will explore over time, because I have a regular catch-up with the CEO of Telstra and a range of different players on this issue.

Senator REYNOLDS: I too participated in the inquiry into the cancer registry, and I think I must have been sitting in a completely different inquiry and reading quite different material. After listening to you answer the same questions I think at least three times, I am even more convinced that I was obviously sitting in a different committee hearing. So, can you just confirm for me that my interpretation of what you have been explaining tonight is actually what you were trying to explain and is correct? What I heard is that you have engaged federally, taken federal leadership on a complex project, involving data integration from all states and territories. Anybody who has been involved knows just how incredibly complex that is, and I do not think a single data integration project in any department has ever gone according to plan A, whether private enterprise or government enterprise.

Mr Bowles: True.

Senator REYNOLDS: You have that. You have new technologies—cytology—and a new workforce, arrangements to work out with pathologists. So, you entered into a contract with somebody who was actually highly technically competent and savvy to undertake complex projects with you.

Mr Bowles: Yes—and, just to add to that, through a rigorous, tender based process.

Senator REYNOLDS: Yes, and that is what I distinctly remember from the inquiry into this matter. I am the glass-half-full sort of person, and listening to what you have described tonight I have to say congratulations to you and your staff, because instead of rushing into something headlong, just to meet artificial deadlines, you have actually done complex project management by the book. You have the right partners—the pathologists, the medical profession, the IT partners. You have the data. You are going through the process of data integration properly. You have brought the pathologists on side. You need a few extra months to implement this properly to start with, and you have implemented interim measures so that there is not any adverse impact on patients. So, instead of rushing it and implementing it now and getting it wrong and fixing it for years and years to come—as so many projects do—bravo, is all I can say. I think it is a great example of how to do a project properly the first time. So, is my interpretation what you were trying to describe?

Mr Bowles: That sounds pretty reasonable, and thank you very much for that. We did go through a range of issues, and it does not always feel like we did a good job, but thank you for your description there. It is exceptionally complex. The professional groups around this—being the pathologists, the doctors and others—have all said to err on the side of making sure that you get this right. That is what we have done. We accept that there are issues with that around delays—all of that sort of stuff. But we have to get this right.

Senator REYNOLDS: Well, thank you very much, and, again, congratulations, because so often on this side—again, the difference, I think Minister: I think this is more of a political question, but I think this actually summarises the difference between those of us who are currently on the government benches and those of us who are not. Some people look at a project in terms of the deadline, and others look at it in terms of how you actually implement it properly the first time.

Senator Nash: I totally agree with that, Senator.

Senator SIEWERT: [inaudible] rushing the legislation—we said it was going to take longer.

Members of the committee interjecting—

CHAIR: Order!

Senator REYNOLDS: Well, after having implemented several of those sorts of projects, I have to say, well done, because you are getting it right the first time. We have a difference of opinion, but well done.

CHAIR: If I can update the department and the committee on the small problem we have of not enough time. The plan at this stage is to conclude outcome 2 by 8.40 pm, which I will almost guarantee is impossible but we will try. Senators have agreed to very much truncated question times. Then we will move to outcome 6, aged care, and hopefully we will finish that

between 8.40 pm and 9.30 pm. Then outcome 5 and outcome 1 have a number of programs that we will not be requiring. I am advised at this stage, we will not require program 5.2, health protection and emergency response; program 1.2, health innovation and technology; program 1.4, health peak and advisory bodies; and program 1.5, international policy. We intend to conclude outcome 5 by 10.05 pm and then outcome 1 by approximately 10.20 pm and then we will move to sport and recreation. I hope this guidance is of use to the department and thank you for your—

Mr Bowles: Just a little question: do people want to talk to FSANZ?

CHAIR: Yes.

Mr Bowles: I just want to go through the agencies. NICNAS?

CHAIR: Yes.

Mr Bowles: The National Health and Medical Research Council, NHMRC?

CHAIR: Yes.

Mr Bowles: The National Mental Health Commission have been on and they are gone?

CHAIR: Yes, retain them.

Mr Bowles: They have already gone because they were on earlier.

Senator SIEWERT: The department staff are still here?

Mr Bowles: The department staff are still here. Thank you.

[20:01]

CHAIR: Senator Watt, on 2.4—very, very briefly if you can.

Senator WATT: I have questions about the Non-Government Organisation Treatment Grants Program and the Substance Misuse Service Delivery Grants Fund. How many grants are currently administered through these two funds?

Dr Southern: Approximately 180.

Senator WATT: 180 across both?

Dr Southern: Yes, that is right.

Senator WATT: Can you easily split that into each program?

Dr Southern: Do we have a split? No, we do not have a split with us.

Senator WATT: Can you take that on notice.

Dr Southern: Yes, certainly.

Senator WATT: How many organisations receive funding through each of these funds?

Dr Southern: It is almost equivalent to the number of grants for individual services.

Senator WATT: It tends to be one organisation per grant?

Dr Southern: Pretty much.

Senator WATT: What is the current value of grants administered under each fund?

Dr Southern: I think in total the amount for alcohol and other drug services under those two programs is around \$80 million a year.

Senator WATT: That covers both funds?

Dr Southern: Yes.

Senator WATT: Do you know how much in each?

Dr Southern: I would have to take that on notice.

Senator WATT: That would be great, thanks. The information I have is there are about 148 organisations with funding, but you are saying it is about 180?

Dr Southern: Some of the services are contracted with one organisation, but it is a number that is close.

Senator WATT: Do all the grants in these funds expire at the end of this financial year?

Dr Southern: Yes, they do.

Senator WATT: In four months time, all of those grants will expire?

Dr Southern: That is correct.

Senator WATT: Have organisations been notified if they will receive funding in the next financial year?

Dr Southern: Not yet, no.

Senator WATT: When do you intend to do that?

Dr Southern: It will be very, very soon.

Senator WATT: Is the funding continuing into next year, that \$80 million?

Dr Southern: The funding is in the forward estimates, but it is a decision for government as to how that is dispersed going forward. But we recognise that the end of those funding agreements is coming very quickly and we need to get out to the services to let them know if they are continuing.

Senator WATT: So that figure of \$80 million per year across both those funds is in the forward estimates, as in for the next four years or just for next year?

Dr Southern: It is ongoing funding.

Senator WATT: So for the next four years?

Dr Southern: Yes.

Senator WATT: Can you guarantee that every organisation that is currently receiving funding will continue to receive that funding next financial year?

Dr Southern: That is a matter for government.

Senator WATT: Have you provided advice to government on that?

Dr Southern: We have provided advice around the programs, yes.

Senator WATT: Is it your recommendation that all those organisations continue to get funding?

Dr Southern: That goes to the nature of our advice to the government. So, yes, we have provided advice around the programs but I will not go into the nature of the advice.

Senator WATT: So it is possible that there will be some organisations that are currently funded that will not have their funding renewed at the end of the year, depending on what government decides?

Dr Southern: As I said, it is a decision for government to take.

Senator WATT: If you cannot say which ones will lose their funding and you cannot say which ones will keep their funding, are you in a position to guarantee that any of the organisations will keep their funding going forward?

Dr Southern: I think it is highly likely that many, if not all, of the programs will continue to be funded. But, as I say, that is ultimately a matter for the government to announce.

Senator WATT: Did you already say when these organisations can expect to find out, given it is four months away?

Dr Southern: 'Very, very soon' is what he said.

Senator WATT: Is that weeks or months?

Dr Southern: Very, very soon.

Senator WATT: The cancer screening was going to be up and running 'very soon' too. There are organisations that have been in contact with us saying that their funding uncertainty is limiting their ability to take on new cases. Wouldn't you agree that this uncertainty is having a significant impact on the ability of the drug and alcohol sector to deliver services?

Dr Southern: I am certainly aware that uncertainty about ongoing funding is always a concern for organisations in terms of their workforce and clients. We have not, as far as I know, had direct contact from people except to say that they are very anxious about knowing the outcomes of ongoing funding.

Senator WATT: Are there any plans to transfer the funding of these functions to the Primary Health Networks, as was the case with the National Ice Taskforce?

Dr Southern: This 12-month period when we extended the contract for the existing service providers was intended as a transitional year to fully understand the commissioning model through the PHNs for the money that was invested in them through the National Ice Action Strategy. So one of the considerations going forward is how the funding is disbursed. It is in the mix.

Senator WATT: It could be transferred to the Primary Health Networks?

Dr Southern: That is a matter for the government to decide.

Senator WATT: Can you guarantee the government will continue to have a direct relationship with these organisations that are currently getting funding?

Dr Southern: Given that it is advice to government and they will make the decisions, I do not think it is my place to offer guarantees.

Senator WATT: Can you tell us how much money has been delivered to frontline organisations from the National Ice Taskforce money?

Dr Southern: \$241.5 million was allocated over four years from 1 July 2016 to the Primary Health Networks.

Senator WATT: When you say the money was allocated to the Primary Health Networks, that does not mean that that money has flowed through to frontline organisations.

Dr Southern: As at yesterday we understand that 25 of the PHNs have executed contracts with 70 service providers, and 19 PHNs have commenced services. That was the contract of that 25, and 19 PHNs have actually commenced services with a total of 61 projects on the ground. The remaining 12 PHNs are just finalising their commissioning processes.

Senator WATT: Have you worked out in dollar terms how much is actually being spent right now operating programs on the ground?

Dr Southern: We would have to you calculate that. We will take it on notice. The money is being disbursed through the PHNs.

CHAIR: If there are any further questions on 2.4, I am very keen for them to be put on notice.

Senator DI NATALE: I want to ask about the ice strategy. Is that in 2.4?

Dr Southern: Yes.

CHAIR: I will do you a deal, Senator Di Natale. You can finish your 2.4 questions and then we will move straight on to Senator Wong.

Senator DI NATALE: Thank you. What is the current status of the National Drug Strategy 2016 to 2025?

Dr Southern: The next version of the National Drug Strategy is due to be considered by the Ministerial Drug and Alcohol Forum when it next meets.

Senator DI NATALE: When is that?

Dr Southern: We do not have a settled date for it yet, but the time frame we are looking at is towards the end of March or early April.

Senator DI NATALE: Wasn't consultation on the strategy concluded more than a year ago?

Dr Southern: Certainly public consultation on the strategy was concluded around about that time. In the interim the announcement of the National Ice Action Strategy needed to be taken into consideration, and then we were in the process of establishing the new Ministerial Drug and Alcohol Forum to consider the matter.

Senator DI NATALE: So we are still without a current alcohol and drug strategy?

Dr Southern: In the interim the existing drug and alcohol strategy has continued to have effect.

Senator DI NATALE: Can I ask you about ANACAD specifically?

Dr Southern: Yes.

Senator DI NATALE: Last estimates we asked some questions about it and we did not really have much information. Can you update us on when the committee last met?

Dr Southern: It was in the very recent past, a fortnight ago.

Senator DI NATALE: What is the schedule of meetings like? How often are they?

Mr Smith: The next meeting is scheduled for May.

Senator DI NATALE: Last estimates we asked about this but you did not have the answer. There is no consumer group rep on ANACAD. Can I ask why the government has chosen not to have a consumer rep?

Dr Southern: The appointments were ministerial appointments and the range of expertise on the committee relates to the range of issues the government was seeking advice around.

Senator DI NATALE: But we have just heard that with the NDS review, for example, there is a consumer rep on each of those committees. Is there any reason not to have a consumer rep on this committee?

Dr Southern: The appointments to the committee were a matter for the minister.

Senator DI NATALE: Okay. That is a question for government. We have seen a number of preventable deaths over the summer—some at festivals and some at clubs and so on. Has ANACAD discussed this specific issue? Have they developed any strategies for responding, including strategies like pill testing?

Mr Killick-Moran: I can confirm that those matters have not been discussed in ANACAD at any length.

Senator DI NATALE: Is that surprising? There have been a number of deaths reported. Twenty people were taken to hospital and there were overdoses very recently—all over summer. As I said, there were a number of deaths at festivals. You have not discussed any of those matters?

Mr Killick-Moran: It has not been on their work plan or on their agenda.

Senator DI NATALE: Okay. Is the department working with state counterparts in any way to look at responses to these issues outside ANACAD?

Dr Southern: It has been discussed in the Community Care and Population Health Principal Committee, the CCPHPC, which sits under the AHMAC structure. There was a discussion there about responses to the sorts of events that you are talking about which have occurred at festivals and other things. There has been a discussion in that context.

Senator DI NATALE: Was the issue of pill testing raised in that forum?

Dr Southern: Not that I recall, no.

Senator DI NATALE: Can I ask you about the Ice Taskforce and the \$300 million commitment. I think \$240 million was provided to the Primary Health Networks. Can I just confirm: is that new money?

Dr Southern: Yes, it was new money.

Senator DI NATALE: That is not money that is coming from other existing programs? This is new money?

Dr Southern: Sorry. The bulk of it was new money for the program but was offset within Health, except for the quantum of funds that relate specifically to Aboriginal and Torres Strait Islander—

Senator DI NATALE: How can new money be offset?

Mr Bowles: That is how a budget works. That is how it has worked for a long period of time.

Senator DI NATALE: Where has it been offset from?

Mr Bowles: From the broader health budget. Every year we will make savings in different areas and that will be used to offset against additional expenditure.

Senator DI NATALE: Has it come from any other drug and alcohol services?

Mr Bowles: The answer to that is no.

Senator DI NATALE: It has not come from NGO programs, flexible funds—

Mr Bowles: The broader part of the health portfolio.

Senator DI NATALE: But those are within the health portfolio?

Mr Bowles: Yes.

Senator DI NATALE: Absolutely not within any of those other areas?

Mr Bowles: No to my knowledge. The way the budgeting works is that we will look at what savings are—

Senator DI NATALE: Sure, we have the MBS freeze et cetera.

Mr Bowles: —going to be achieved, and all those sorts of things.

Senator DI NATALE: But no money has been taken from existing programs?

Mr Bowles: I would have to take that on notice to be absolutely clear, but I am not aware of any money coming out of drug and alcohol type programs to put back into drug and alcohol type programs.

[20:16]

CHAIR: We will now move to program 2.5.

Senator WATT: I have some questions about Health Care Homes. The Prime Minister has described Health Care Homes as his 'signature health care reform'—pretty grand. Will it be rolled out as planned on 1 July 2017?

Mr Bowles: We are currently evaluating that issue with the new minister.

Senator WATT: Remind me: so the commitment is to roll that out from 1 July 2017?

Mr Bowles: The commitment is to work with the sector on what the sector believes is the most appropriate way to deliver this program. The current date is 1 July.

Senator WATT: But that is under discussion with the new minister?

Mr Bowles: And the sector.

Senator WATT: Given that over the course of the day we have had several initiatives that have ended up being delayed, can you guarantee that that will be rolled out as planned on 1 July?

Mr Bowles: I am not into giving guarantees, I am afraid. You can link it to a whole range of other things if you wish. I do not accept that as the basis for this. This is, again, an issue that has to be done with the doctors in particular but with the sector more broadly. We will continue to do that. We will take advice from the sector on that issue and continue to do that.

Senator WATT: When were talking about the cancer register you said that you became aware of risks that it would be delayed before Christmas. So it is sounding very much that you believe there are risks that this rollout date on 1 July will not be met for Health Care Homes. How would you describe that risk: low, medium or high?

Mr Bowles: I am not going to ascribe or attribute a risk to it at this point. This is a matter for the government to make ultimately, but we will deal with the sector more broadly on this issue.

Senator WATT: Have you provided any advice to government on the need for a delay?

Mr Bowles: We are providing advice to the minister on a range of issues to do with many of our programs, one which is Health Care Homes.

Senator WATT: You have talked about discussions you are having with the sector. Have you discussed with the sector the potential that this might not be met by 1 July?

Mr Bowles: If you were to follow the media, the sector has actually asked for it to be delayed a little bit, as well. We are in constant conversations with the sector about what the best way is to handle this project.

Senator WATT: In late November last year, the former minister reaffirmed that Health Care Homes would roll out on 1 July. Why might a delay be necessary now?

Mr Bowles: I have not said there is one at this point. You—

Senator WATT: But you are very pointedly not confirming. Can you reaffirm—

Mr Bowles: It is not my job to confirm or deny anything.

Senator WATT: Senator Nash, can you reaffirm the commitment from both the Prime Minister and the former minister that this will be up and running on 1 July?

The

Senator Nash: That was absolutely the commitment they made.

Senator WATT: My question to you is: can you reaffirm that?

Senator Nash: I am not going to sit here and guarantee things into the future, but I am going to say that this government is doing everything it possibly can to ensure the timely rollout of this and other things that we have been discussing tonight. We have canvassed at length various things tonight in terms of dates and finalisations—

Senator WATT: Usually in the context of them running behind schedule.

Senator Nash: I think we have also canvassed very good reasons of complexity why that has been the case.

Senator WATT: But why are those—

Senator Nash: It is not a buzzword; it is a fact. You might be of the view that we should be rushing things through and not doing them properly, as Senator Reynolds very eloquently pointed out before. But we want to ensure that we have got things right.

Senator WATT: So the department does not do a proper risk assessment before these kinds of dates are set?

Senator Nash: That is just ridiculous. Of course they do.

Senator WATT: Why do we keep coming up with programs—

Senator Nash: I am not going to accept that.

Senator WATT: What have we had today? There was the cervical register, the glucose devices at the very beginning of the day—what have I forgotten, Senator Di Natale?

Mr Bowles: I am sorry, Chair—I do not accept this characterisation.

Senator REYNOLDS: Chair, can I make a point of order?

CHAIR: Yes, Senator Reynolds.

Senator REYNOLDS: Chair, I note that you have spent a lot of time with our colleagues here working through time management. I think wasting a lot of time like this now is not very helpful to getting through the program that senators want for this evening.

CHAIR: I will remind senators that we have a very strict time line, so we will—

Senator WATT: I said it would take 10 minutes and I will not be going beyond 10 minutes.

CHAIR: You have five to go.

Senator WATT: Thank you. If there is a delay, what would the risks of delay be? To be fair, with the cancer register the department's submission outlined what the risks of delay in implementation of that would be. So the department has a practice of advising the Senate of the risks of delay in programs. In this case, Health Care Homes, what risks would arise from a delay in implementation?

Mr Bowles: There would be very limited risk that I can understand in the program. The big issue here is getting this program right around the stratification of patients, around the blended funding models that we are looking at. There are a range of issues. It does not change in any way, shape or form the treatment that would be provided to individuals. They are currently getting that treatment today, they will get it tomorrow and they will get it on 1 July, irrespective.

Senator WATT: So why is this program needed, if delays—

Mr Bowles: Because it is about fundamentally rethinking the model, particularly for patients with chronic and complex disease. It is very, very evident that we can do this better over time. We are leading the world in some of these things. We are the first to try a range of things in this context and we do not apologise for trying to push the boundaries on some of these issues. We will continue, as I said, to work with the sector to get this right, over and above any time frame, because it is important for patients that we get this right. It is important for the sector more broadly. It is a major reform.

Senator WATT: If this is delayed, there are no risks that arise to patients, to GPs?

Mr Bowles: No.

Senator WATT: No risks?

Mr Bowles: No risks. Patients will get treated. We currently have an MBS structure. We currently have a transactional nature to our MBS structure that means patients will continue to get treatment. It is very wrong to characterise things as risks that do not exist. I think that is a real problem that we have an identification of this 'mystery risk' around patient care. It is not a risk to patients.

Senator WATT: Okay. So we are only three months away from the rollout starting, under the previous commitment. When will a decision be made as to whether that is going to be met?

Mr Bowles: It is a matter for government, ultimately. We have been over this multiple times.

Senator WATT: Just to round up, I have given both you and the minister multiple opportunities to reaffirm that that 1 July date will be met. You have clearly not been willing to

do that because you say that is a matter for government. Can you guarantee it is going to proceed?

Mr Bowles: I have said multiple times I am not in the process of guaranteeing. It is not my job. I am not the policy setter here. Government is. The minister is. It is a clear policy of the Prime Minister's and the minister's—and the former minister, for that matter—and my view is that yes, it will proceed. We will get it right, though. We will not forsake the integrity of something just for the sake of a deadline. I am not suggesting for one second that this is in that state, but I want to make a point about this. Did I amuse you then, Senator?

Senator WATT: No, no. Okay, so it will proceed; we just cannot guarantee that it will be on 1 July.

Mr Bowles: Again, I am not going to get into that debate.

Senator Nash: If we are going to talk about timing, Senator, perhaps we should start talking about Labor's GP super clinics and have a look at the timing issues around those?

Senator WATT: They went pretty well.

Senator Nash: That must have been before your time, Senator Watt, or you would not have said that.

Senator WATT: They were the ones that you took funding away from? I am done.

Senator SMITH: I think this is an important point, secretary. Without wanting to be rude, the department is very well informed of the need to do things well and properly. There have been some very bad examples, costly to the taxpayer, of policies that were poorly designed and poorly implemented. The one that comes to mind—and I am sure Senator Polley will recall this—is the dementia and severe behaviours supplement, which cost the taxpayer tremendous sums of money and did little to improve dementia care. I am not wanting to put you in a difficult position, but are there any other examples of poorly designed, poorly implemented policies that have informed you and the department in terms of perhaps taking extra care and prudence around this government's initiatives?

Mr Bowles: If you look at my history, you will probably see that I have been involved in the rectification of some very interesting projects, like the home insulation scheme. So I am very acutely aware of governance issues.

CHAIR: There is a point of order before the Chair from Senator Polley.

Senator POLLEY: We are very limited on time. If this is about making political points then that is great, but some of us actually want to get on to our real issues.

Mr Bowles: I made the point in the context of my past and why I have a particular interest in governance and in getting things right.

CHAIR: And I have ruled there is no point of order. Senator Griff, your questions, please.

Senator GRIFF: I would like to seek some clarification on the Health Care Homes program. How are the outcomes of the trial being measured?

Mr Cormack: The Health Care Homes program will be subject to a rigorous external evaluation program. We have contracted a company to undertake that; they will look at the health outcomes of the patients who are in the trial. They will look at the process and the project, and how it is being implemented—

Senator GRIFF: This is a national company?

Mr Cormack: Yes.

Senator GRIFF: Who is that?

Mr Cormack: The company is Health Policy Analysis. They are very skilled program evaluators, and they will look at all aspects of the program. The felt experience by consumers, the impacts that it has on practices, the effectiveness of the new payment arrangements, the education and training that needs to be undertaken to change management—they will look at all of those aspects. We are just working through with that company at the moment. We have been on board for a little while now to shape up the format of the evaluation.

Senator GRIFF: Obviously, the Commonwealth is looking to contain costs with the program. That would be—

Mr Cormack: In fact, what we are attempting to do with this arrangement is to provide a more appropriate model of care for this group of patients. Clearly, we need to be mindful of operating within the existing funding parameters that we have got, and that is broadly the way the project is set up. But what this is really about is the biggest single burden—both a financial burden and a health burden—on our system, which is the growing impact of chronic disease and the risk factors associated with that. If we are serious about managing the long-term financial impacts of our healthcare system and providing the best quality care for patients, then we need to do a range of reform exercises to make sure that we can get best value for money by providing the right care at the right time in the right place. That is really what this is all about. It is not a cost containment exercise. It is about providing better care and better managing downstream effects, because we are seeking to avoid costly hospital admissions that could have been prevented by better quality care in general practice and in the primary healthcare settings in people's homes and engaging people in undertaking actions that look after their own conditions. That is what this is about.

Senator GRIFF: Am I right in saying that the patient can still access unlimited MBS rebates for visits not related to their chronic condition?

Mr Cormack: Correct.

Senator GRIFF: Doesn't that undermine the purpose of the program?

Mr Cormack: No, because the purpose of the changed payment model is to bundle up the anticipated number of consultations of certain types that would have been associated with the person's chronic disease and to give the healthcare home, the practice and the practitioner the flexibility to provide the best possible care outcome without necessarily having to have the patient turn up every single time and undertake a Medicare transaction for every aspect of care that they are getting.

Senator GRIFF: Are you planning on, in effect, measuring hospitalisation that has been prevented?

Mr Cormack: Yes. That is a key part of the evaluation.

Senator GRIFF: Given that practices do not have to return any unspent patient care funds, what incentive is there to deliver the type of care you are aiming for?

Mr Cormack: The greatest incentive that the practices and the GPs have is to provide the best possible care for their patients. That is what motivates the sector, and that is what—

Senator GRIFF: Will you be auditing practices?

Mr Cormack: There is the evaluation framework that I describe, but we also have a compliance and assurance framework that will be tailor-made for this program, and that is what we are working through with the sector at the moment.

Senator GRIFF: Given that they are paid \$10,000 as a one-off grant to assist with the practice changes, are there any limitations on how that \$10,000 is to be used?

Mr Cormack: It is a flexible pool of funds. It is meant to cover system changes, some contribution to any training or education—

Senator GRIFF: But it is up to them to decide how they wish to spend that.

Mr Cormack: It is up to them, that is right.

Senator GRIFF: What if they withdraw from the program? Do they have to repay the \$10,000?

Mr Cormack: That will be part of our compliance and assurance framework. We will—

Senator GRIFF: Will that be part of their contract?

Mr Cormack: We are just working through the details of that particular aspect with them, but our intention is to keep the healthcare homes in the program, and we have been very successful in terms of attracting more than twice the number of applications that we actually need to do that.

Senator GRIFF: I think we could safely assume that if somebody does withdraw there will be some requirement for them to repay.

Mr Cormack: We have to work that through, because there could be a range of unforeseen circumstances that could contribute to that. These are, in the main, their businesses. They are subject to the normal pressures that businesses are under, so we will need to look very carefully—

Senator GRIFF: Who decides if the enrolment is accurate?

Mr Cormack: We will have an assurance framework in place. We will have a series of training and education requirements that the practices will need to undertake. They will contribute to an evaluation framework. There will be a lot of scrutiny, but we think it will be positive scrutiny because we know that both the patients and the doctors are united in trying to get the best possible outcome for them and to avoid preventable hospital admissions. That is the good thing about this.

Senator GRIFF: I think we are all on the same page with that. Just going back to the question I tried to ask previously, why is diabetes monitoring not mentioned in the healthcare homes evaluation as a performance outcome measure?

Mr Booth: As Mr Cormack said, the intent is for the healthcare home to look at all chronic diseases in totality and to try to move away from a single chronic disease model that has been tried in the past, and the evidence is that you need to look at that because this is specifically around patients with multimorbidities—they are suffering from multiple chronic conditions—so we will of course be including diabetes and patients with diabetes, but there is not a specific measurement around individual diabetes, asthma or whatever. It will be more around the wider experience of the patient.

Senator POLLEY: I want to ask some questions related to the Primary Health Networks, and the changes that have taken place with their direction. You no doubt would be aware that it is not just people like me that have raised the issues and concerns that people within the Tasmanian community have. In fact, government senators have also raised their concerns about the change. Could you walk us through the consultation process and the direction that the minister gave to the PHNs in terms of the changes moving from preventative health in dealing with chronic health diseases?

Ms Cole: The government gave six priorities to the Primary Health Networks. Those six priorities are aged care, chronic disease, digital health, workforce—

Senator POLLEY: Actually, I know what the priorities are, and we are short on time. Can you step us through the consultation process that the government directed the PHNs to undertake with these changes?

Ms Cole: The PHNs do not do a consultation per se. What they do is a needs analysis first in terms of their population needs. Then they do a planning process around activities and so forth, and as part of that activity process, the commissioning process, they do extensive consultations with the local communities around what services have been identified as being needed in the needs analysis and how those needs might best be met.

Senator POLLEY: Do they have to provide that consultation and the processes they went by to the government?

Ms Cole: They provide the needs analysis and the activity plan. Both of those are formerly checked by the department before they can proceed any further, and they generally indicate to us, as part of that process, how they have got to the needs analysis and the activity plan, which includes that sort of consultation process.

Senator POLLEY: Can you table those for the committee?

Ms Cole: The activity plans and the needs analyses are generally on every PHNs website and are publicly available at the moment.

Senator POLLEY: The Prime Minister made very clear that preventative health was one of his signature health outcomes he was concerned about. What we have seen is a transfer of resources from those communities that were doing very well and using their community centres. I could go through some of those: the Kentish municipality, the Meander Valley, the Tasman Council and the Southern Midlands Council are all questioning the process of consultation that was undertaken when this major reform was thrust upon them.

Ms Cole: They basically prioritised need within those communities, and there was some discussion therefore with various communities about where the highest need was and whether some of those services could be funded through alternate means in order to ensure that there is a good balance and focus of services in communities right across Tasmania.

Senator POLLEY: Could you explain to me then, if you live in Kentish Municipality, and you are an 85-year-old woman, and you need a particular service, and you have to travel to the east coast of Tasmania, how is that in the best interests of those communities? I would have assumed the government, through the department, would want to have seen evidence-based consultation before they allowed setting up and this process to be undertaken.

I have spent all day listening to every other health outcome being discussed. It has been really important, whether we are talking about mental health or youth or drugs. But all those services have been taken away from some if not all of these municipalities I have just identified.

Ms Cole: I do not believe that is quite correct.

Senator POLLEY: Sorry. I was at a public meeting with Senator Duniam last Tuesday evening where it was very clear that there had not been adequate consultation with their community. In fact those services—the youth worker—have been taken away. They had quite a high incidence of youth suicide and youth crime, which had been reversed in those communities over a number of years. They now no longer receive those services, and that is without the other impacts that social workers in that community put together. They do not believe that there was adequate consultation. I want to see some evidence of it, so that I can go back to my communities and stand with Senator Duniam and convince those communities that the government is clearly satisfied that the new preventative health changes that have taken place are in the best interests of our communities.

Mr Cormack: I just want to clarify something here: the scope of the PHNs is not just about preventative health care services; it is about primary health care services overall.

Senator POLLEY: That is right.

Mr Cormack: They are responsible, as Ms Cole said, for undertaking a needs analysis—and we understand that that was undertaken—and then to follow that up with a commissioning process and an approach to the market to put in place services that match their needs analysis. We understand there was extensive consultation, but clearly, in some instances, some aspects of the community were not happy with that consultation process. I acknowledge that. I am not challenging that view.

Senator POLLEY: To help me and others, can you explain to me what your understanding of consultation with a community is. Is that about getting a number of people in a room and having someone talking at them? Is that consultation?

Mr Cormack: There can be a number of ways. We do not specify the precise methodology of consultation, but consultation effectively means engaging with those members of the community and those members of, in particular, the health providers to make sure that before final decisions are taken they have had the opportunity to provide input into a process. That is the generally accepted definition of consultation. But we do not specify: 'You must have six town hall meetings; you must have this sort of survey'. It is their job to undertake the consultation so that people are engaged in the process.

Senator POLLEY: I will put some questions on notice to follow this up, because I do not think you, Senator Duniam, or I can go back to our communities, having been at estimates, and try to explain to the communities there that they are getting fair service.

CHAIR: You are quite right, Senator Polley; thank you very much. Senator Leyonhjelm, you have a very brief two-minute bracket.

Senator LEYONHJELM: Because I was being hurried up, I skipped a question when I was in here before. Mr Bowles would be interested, and Dr Southern might also be needed. It concerns plain packaging and the contract between the health department and Cancer Council

Victoria that was to look at the impact of plain packaging and determine whether it was successful or not.

The contract between the health department and Cancer Council Victoria was published late last year, and the final reports were to include consideration of the impact of packaging changes on key proximal outcome measures, consideration of independent and combined influences of plain packaging, health warnings, mass media campaign exposure, any tobacco pricing and product changes and also the impact on quit intentions, quit attempts and consumption. Professor Sinclair Davidson and another author then wrote a paper basically challenging the results of the Cancer Council Victoria survey. As a consequence, Cancer Council Victoria put out a press release in which they said their study was:

... quite explicitly *not* designed to assess quitting success or change in smoking prevalence but rather focussed on the immediate impact of the legislation on perceptions of the pack, effects of health warnings and understanding of product harmfulness.

The separate review, which was a post-implementation review, also commented: 'Given the timing of these changes, it is not possible to separately identify the effects of tobacco plain packaging' from those of other changes—

Mr Bowles: Sorry, Senator, you have passed all of us, I am afraid. We have no knowledge. We are happy to take that on notice.

Senator LEYONHJELM: This is a question relevant to your earlier point about your concern about programs and needing to fix them up. I will provide this information on notice, but the point is that \$3 million—in fact \$3,084,000, to be precise—was spent on this study involving Cancer Council Victoria in which the contract said, 'You will do certain things,' the results said, 'You can't do those things,' and another study, almost concurrently, said, 'You can't do those things anyway.' It looks to me, on the face of it, that we did not get very much for our \$3 million, and certainly not what was contracted.

Mr Bowles: I am happy to take it on notice.

Senator LEYONHJELM: You have no knowledge of it?

Mr Bowles: I have no knowledge of it whatsoever.

Senator LEYONHJELM: Okay. Thank you very much.

CHAIR: Senator Di Natale, your five minutes starts now.

Senator DI NATALE: I have some questions on Health Care Homes again. I will start by saying the reorganising of primary care in a way that focuses on chronic disease is an initiative worth considering, so I do not come at this from a place of being at all oppositional to trying new things. Have you got an implementation timetable for rolling out the reform?

Mr Bowles: Yes. That is where we got to before, with 1 July. What I am saying is that there have been some issues with the RACGP and the AMA—they have been in the public arena—around wanting more time around patient stratification. That was the point I was making before. That is not an agreed decision but it is in the public arena, so I raise it in that context.

Senator DI NATALE: Yes. I am aware, because I speak to them as well.

Mr Bowles: I just want to put it in that context. But, prior to that, clearly there has been a rollout to hit a 1 July target. It is up to government now to decide how that proceeds as far as the timing goes.

Senator DI NATALE: It is still on the website as 1 July.

Mr Bowles: Yes, that is right; it still is.

Senator DI NATALE: I imagine that will be reviewed if there is a change at some point. Have you identified all of the practices that will be involved?

Mr Bowles: I will get the team to answer that, but just in the broad—just in case that might do, given the time—462 applications for 200 are going through the process at the moment. They have not been finalised. They will probably be finalised shortly.

Senator DI NATALE: Sorry: was that 462 applications for a couple of hundred—

Mr Bowles: For 200 practices. So it is oversubscribed.

Senator DI NATALE: That is interesting. What do you attribute that to?

Mr Bowles: Interest.

Mr Cormack: It is a good program.

Senator DI NATALE: But the AMA and the RACGP are concerned. Are they perhaps not reflecting the desires and wishes of some medical practices?

Mr Cormack: I think that is a question you could ask the senior officials in the AMA and the college. We have had extensive involvement with the AMA and the college in the governance of the project. They are very active in the various working groups that have contributed to the elements of it. They continue to be around the table, and in fact their members are counted against the 462 practices. So there is good engagement here.

Senator DI NATALE: When did you finalise the list of 200 practices?

Mr Booth: As the Secretary said, we are just going through the assessment process. We are hoping that that assessment process will be completed within the next week or two. That will then come up with a list of practices that we think are suitable. What we are actually doing is using a sampling frame methodology to make sure that we get a good spread of practices, because we want the large, the small; the corporate, the single-handed; the rural, the urban.

Senator DI NATALE: Yes. Gotcha.

Mr Booth: We have then got to start slotting them into those and making sure. We will just work through that in the next few weeks.

Senator DI NATALE: You had a list of PHNs on the website.

Mr Bowles: Yes.

Mr Booth: Yes. That is correct.

Senator DI NATALE: Aboriginal medical services are obviously part of the mix.

Mr Booth: Yes.

Mr Bowles: Yes.

Senator DI NATALE: How many?

Mr Booth: A good number did apply.

Senator DI NATALE: Do you have a set allocation for how many?

Mr Booth: We did not have a set allocation, no, but there was certainly a good number.

Mr Cormack: It is within the sampling frame. We need to capture those. They will be represented in the sample.

Senator DI NATALE: You would imagine, what, a handful?

Mr Cormack: There will be enough for us to be able to demonstrate whether or not the trial is working.

Senator DI NATALE: Okay. So obviously none of those practices have been advised yet. Have you made any changes to the trials as a result of your engagement with the AGM and the college?

Mr Cormack: I think what we have been able to do with our engagement to date is come up with a risk stratification model. We started with an outline. We now have a much more refined risk stratification model. We have an education, training and engagement piece. We have a compliance and assurance framework that continues to be updated through the engagement that we have. We have a care model.

Senator DI NATALE: So you are building on it.

Mr Cormack: Yes.

Senator DI NATALE: But just in terms of changing things that you had originally started with—the funding envelope or anything of the sort—

Mr Cormack: The funding envelope is the same, so that has not changed.

Senator DI NATALE: That has obviously been one of the criticisms from the AMA and the college.

Mr Cormack: The funding envelope has not changed, so it is still there. But with the implementation, even though we are talking about 1 July, an awfully significant amount of work has been undertaken in the lead-up to that to develop the model, and it has continued to be refined, developed and sharpened up through extensive engagement with a whole range of organisations, not just the AMA and the college; consumers are involved as well.

Senator DI NATALE: I think that probably covers it. Thank you.

[20:50]

CHAIR: We have now finished speed-dating with program 2.5, so we will now go to 2.6, where Senator Siewert has seven minutes of questions.

Senator SIEWERT: I will try to get them done before that. I want to ask about PIP. You will be aware that there is a lot of concern from Aboriginal community controlled health organisations about the proposed changes, and I understand that there was further work being done on that issue. That is a correct understanding, isn't it?

Mr Cormack: Yes. You are talking about the PIP quality improvement incentive, which is a proposal to look at a number of the existing PIP payments to see if we can streamline them, consolidate them and make them more flexible but focus on the key objective of quality improvement. There has been extensive engagement over a significant period of time to refine a model. I have to say that work is still in play. We are very acutely aware of the Indigenous PIP, and we are working very closely to ensure that whatever we come up with does not in

any way disadvantage any of the existing practices and, in fact, enhances them. So we have not settled on a final outcome there, and we are continuing to engage extensively with all of the relevant groups, including the ACCHOs and others that are engaged and are using the existing PIP incentives. It is not settled yet, though.

Senator SIEWERT: Thank you. It is good to hear that you are hearing their voices. My understanding is that there is now, as you have just said, specific focus on the Indigenous component.

Mr Cormack: Yes, there is.

Senator SIEWERT: Where are you up to in that extra consultation that is going on and the process specifically around that?

Mr Cormack: We have had six structured workshops to date.

Senator SIEWERT: Are they specifically on the—

Mr Cormack: On all of the PIPs. Specifically, we have had the Aboriginal and Torres Strait Islander practice representatives engaged in looking at theirs. I might just get Ms Cole to talk to us about the next steps and where we are up to.

Ms Cole: Essentially, the next step is that we have consolidated all of that fairly extensive feedback we got through consultation. We have a group called the PIPAG, which is the Practice Incentives Program Advisory Group. That has, basically, all the major stakeholders on it, including a representative from NACCHO, and we are, in a sense, working through model variations to address the issues that have been raised in the consultations. We have a meeting of that group next week.

Senator SIEWERT: Has there been a decision to retain the Indigenous incentive component?

Mr Cormack: We have not finalised a decision on that, but we are looking very closely, and we are doing some quite detailed analysis of positive outcomes and any unintended outcomes. It is literally still in play. We are acutely aware of the issues that have been raised by the sector. We are confident that we will be able to come up with an arrangement that does not disadvantage them but still achieves the overall aim of simplifying the range of PIPs that are in scope for this.

Senator SIEWERT: The other issue that I have had concerns raised with me about is to ensure that the requirement for all mainstream health services to undertake cultural training is not lost either. Where are you at with that?

Ms Cole: Essentially, what we will be doing is creating a PIP which allows practices to indicate areas of improvement that they wish to work on in the long term. One of those areas of improvement might well be, for example, cultural safety training—that kind of thing.

Senator SIEWERT: But, surely, it should not be a choice. That is what the organisations are asking for—that is, it is not a choice but a requirement that cultural training is undertaken.

Ms Cole: At the moment, my understanding is—and I will come back to you on notice to confirm this—that only if you claim that PIP do you have that requirement. So what we are suggesting is that, by moving to this overarching quality improvement PIP, you may well be able to encourage more practices to undertake that kind of quality improvement activity, which, as you say, all practices should do. The other way to address this very issue that you

are talking about is to look at the accreditation requirements long run. That may actually be a more effective way of addressing the issue that you are raising.

Senator SIEWERT: That is a good point. Thank you. I have one last one. What are you going to be doing with the current system—the annotating of the PBS prescriptions as part of the co-payment measure?

Ms Cole: That is one of the finer points that we are going to have to work out in this system because it is a very important component of that Indigenous PIP. We will need to ensure that there is some capacity to ensure that those drugs are still available for Indigenous—

Senator SIEWERT: And the time line for completion.

Ms Cole: We are hoping to have something finalised in the next few months for consideration by government.

Senator GRIFF: I would like to discuss after-hours primary health care. I understand there are two primary options for the public. You have private GP practices and the corporate medical deputising services. Firstly, I will go to private GPs. My understanding is that the PIP is utilised by private GP practices for after-hours care.

Ms Cole: Yes, that is correct. There are after-hours items in the MBS and there is also a PIP payment depending on the level of after-hours provision that a practice makes.

Senator GRIFF: What do GP practices have to do in order to receive this?

Ms Cole: It varies depending on the level of payment. I can provide that to you on notice. It is reasonably detailed around the difference—

Mr Cormack: Just to run through, very quickly, what we are talking about: there are five levels for the after-hours PIP. There is a payment rate that varies from one dollar per SWPE—which is standardised weighted patient equivalent, I think—right up to \$11 dollars per SWPE. For example, at level 1 its participation is: full after-hours period outside 8 am to 6 pm on weekdays; formal arrangements in place with other providers, including medical deputising services, to ensure access for patients. Then it goes right through to level 5, which is a full after-hours period covered with a participating general practice. So a practice is, actually, effectively arranging for that full cover themselves. Between one and five there are differing levels, and the payment is adjusted accordingly.

Senator GRIFF: In the interest of time, I will put some questions on notice and move on to the corporate medical deputising services. Can you provide a breakdown of the total cost of this service for the Commonwealth?

Mr Cormack: We will take that on notice.

Senator GRIFF: What proportion of total funding was for urgent after-hours visits, specifically items that—

Mr Cormack: That is a different outcome. I think you are talking about the MBS payments—is that right?

Senator GRIFF: Yes.

Mr Cormack: We will take that on notice as well, because it is in one of the earlier outcomes.

Senator GRIFF: I understand that the amount of MBS rebates being paid for urgent after-hours services is escalating significantly, and that it has doubled between 2010 and 2015.

Mr Cormack: Same; we will have to take that on notice.

Senator GRIFF: I will send you separate questions regarding that. Also, as it turns out, my home state is the heaviest user of item 597, but again I will send that to you. Do you actually know the proportion of those patients that attend their usual GP the following day?

Mr Cormack: No. We will take it on notice. I am not sure we will be able to answer that; it is more in the MBS world.

Senator GRIFF: According to various news articles, many of these after-hours GP services rely on less-experienced or overseas-trained doctors. Is there any concern over the standard of care that these doctors are providing?

Mr Cormack: I think that is not necessarily a question we can answer. The medical board would have a view on whether doctors are appropriately qualified or not in that context. The MBS review process is actually looking at the whole after-hours issue, so we will take that on notice and deal with it in that context.

Senator GRIFF: That is good. Just on that: as you are probably aware, in the US there have been prosecutions by the FBI of doctors who were rorting their Medicare on quite an industrial scale for after-hours home-health services. I imagine you are aware of this. Are you undertaking any kind of review yourself as part of this MBS review?

Mr Cormack: Not as part of the MBS review, but we have a MBS-PBS compliance group that actually looks at all manner of things that are inappropriately charged, if you like, in that sort of context.

Senator GRIFF: Thank you. The rest of them I will send on notice.

CHAIR: We will now move to FSANZ, so thank you very much, program 2.6. And we are not doing 2.7—those officers have been advised not to hang about, I understand.

Food Standards Australia New Zealand

[21:02]

Senator KAKOSCHKE-MOORE: My questions are focused mainly around commercial milk formula for children over 12 months of age, but first I have a general question. I am aware that FSANZ does not enforce the Food Standards Code, but that the role falls to state and territory agencies. Does FSANZ refer potential breaches of the code to state and territory agencies?

Mr May: If we are made aware of an issue our general response will be to refer the person who informed us of that possible offence to the relevant state and territory authorities.

Senator KAKOSCHKE-MOORE: You would refer the person to approach the state or territory authority; you would not make the approach to the state or territory authority yourself?

Mr May: Indeed, because we do not investigate, so we have no facts to provide to them.

Senator KAKOSCHKE-MOORE: But if a person provided you with the facts, and you said, 'This is for the states and territories,' you would not pass on that information?

Mr May: We would generally ask them to take that action. If we become aware ourselves of an issue, we will occasionally informally advise the states and territories either through what is called ISFR, where we could raise the issue for general discussion—

Senator KAKOSCHKE-MOORE: What was that, sorry?

Mr May: The Implementation Subcommittee for Food Regulation, which is a subcommittee of the Food Regulation Standing Committee.

Senator KAKOSCHKE-MOORE: This space is quite convoluted!

Mr May: We could do that or we might, at an informal level, speak to the enforcement officers in the states or territories.

Senator KAKOSCHKE-MOORE: But there would not have been an occasion where you would make a formal report?

Mr May: No, because we are not an investigative agency and we are not an enforcement agency.

Senator KAKOSCHKE-MOORE: I will turn now specifically to the topic of regulation of infant milk formula. Does FSANZ view toddler formula promotion which implies health or nutritional advantages such as in the product name, trademark or logo as breaching Australian food standards regulations?

Mr May: We do not have a view on that.

Senator KAKOSCHKE-MOORE: No view?

Mr May: No view.

Senator KAKOSCHKE-MOORE: At all?

Mr May: That is a matter for the states and territories; that is not a matter that is regulated, as I understand it.

Senator KAKOSCHKE-MOORE: Yes, I think that is part of the issue. What action is available for FSANZ to take? You are saying you would refer it to the state and territory agencies if, just from your own observations, you became aware of some marketing that you thought, 'I don't like the look of this.'

Mr May: In a range of areas, and infant formula is one of those, the states, territories and FSANZ run a coordinated surveillance and monitoring program. From time to time, issues such as the labelling of infant formula, or other issues related to infant formula, will be part of that program. There is an ongoing mechanism for the regulators to become aware of issues in the marketplace and, of course, they go out and do their own work in the marketplace.

Ms Flynn: I think you are talking about marketing and advertising of infant formula. There is a system set up whereby there is a tribunal that considers noncompliance. I want to stress that infant formula is defined as formula for infants up until the age of 12 months only.

Senator KAKOSCHKE-MOORE: Yes.

Ms Flynn: But, if it falls within that definition it is referred to a tribunal.

Mr May: I understood the question was about toddler milk.

Senator KAKOSCHKE-MOORE: Where is that tribunal located? Is it within the Department of Health?

Ms Flynn: No, it is not in the Department of Health. It is serviced out of an organisation called The Ethics Centre in Sydney. The usual way that things are referred to the tribunal is that someone will write to the department, we look at the complaint and get a sense of whether it looks like it is in scope of the MAIF agreement and then, if it is, we refer it.

Senator KAKOSCHKE-MOORE: I see. So if it relates to formula that is marketed towards children who are older than 12 months—

Ms Flynn: It is out of scope.

Senator KAKOSCHKE-MOORE: I see.

Senator RICE: I want to follow up on two areas that I had discussions with you about at the last estimates. One is on your work on new GM techniques and the second is on the use of nanomaterials in foods. In May estimates last year you said in terms of the expert panel on GM that FSANZ is not aware that any members of the expert panel have potential conflicts of interest such as a commercial interest or patents in any of the listed breeding techniques. Would you agree that, in having a committee to advise you, you would want to have a broad spectrum of views in order to get the best expert advice rather than having a panel that would largely be composed of people who potentially did have conflicts of interest?

Mr May: The purpose of the advisory committee that we are talking about was to provide expert scientific advice, not to provide broad, general advice to answer what I will describe as a policy question. So, really, we did want to have people on that group people who were working in the field. Obviously, issues around direct conflicts are important but, equally, we needed to have people who were active in the field and who could provide expert commentary to the experts in the FSANZ staff to supplement their knowledge and to provide information about what is happening generally in the industry.

Senator RICE: Did you have any panellists that had other, broader expertise in toxicology, ecology or risk assessment in those advisory panels to balance the experts that could potentially have conflicts of interest?

Mr May: As I understand it—and I was not involved in the process of selection—the group was put together to provide that broad range of expertise. It may well be that you could identify people who were not selected who might have provided similar information or similar views, but that group was put together as an expert group to provide that advice, and our view is that it was an appropriate group to provide the expert advice that we were looking for.

Senator RICE: But you are basically saying they did potentially have conflicts of interest, however, because they were involved as scientists in the field.

Mr May: If being active in the scientific work in that area is a conflict, that is possibly the case. If you are talking about commercial conflicts or what we would call material conflicts of interest, we are satisfied that they were weeded out through the process of declaration of conflicts of interest.

Senator RICE: That does not seem to be consistent with the statement that you made to estimates in May last year that FSANZ is not aware that any members of the expert panel have potential conflicts of interest, such as a commercial interest or patents in any of the listed breeding techniques. We recently had a document released under FOI where the chair of the panel said, 'I'm happy to chair the meeting, if you don't feel my potential conflict of interest is

a problem.' I have a list of nine people who were on the panel, all of whom were listed as inventors in a number of gene technology patents, so clearly they had potential conflicts of interest.

Mr May: It is acknowledged that they all had potential conflicts of interest, but there is a difference between a potential conflict—it would be very hard to find an expert who did not have a potential conflict of interest.

Senator RICE: So what is the difference between a potential conflict of interest and a conflict of interest? If indeed all of your panel members are inventors on patents and are actively involved, they have commercial interests in gene technology.

Mr May: I think you have to look at what the panel was being established to provide advice about. It was not being asked to provide advice about the toxicology of the products of the techniques; it was being asked to provide advice about the actual techniques that are the subject of questions about whether or not the current regulations apply to the products. So it was very much about the scientific methods that go to produce those particular products of technology. Having a broader range of risk assessors or toxicologists was outside the scope of that particular expert advisory committee.

CHAIR: I am very sorry, but we are very tight for time. Any further questions unfortunately will have to be on notice. Thank you very much for your answers.

[21:13]

CHAIR: We have finished with outcome 2 and so we are now going to move to outcome 6, ageing and aged care.

Senator POLLEY: I have some questions around the ACAT assessments. The number of ACAT assessments performed annually has actually reduced, with the figures that I have been provided, from 223,649 in 2013 to 192,087 in 2015. Can you explain to what the reason would be behind this? Bear in mind that we have to be very succinct if we can.

Ms Buffinton: I did not actually catch the figures, but I could hear that it was 2013 through to 2015-16. Was that the time frame?

Senator POLLEY: Yes. There has actually been a decline in the number of assessments that have been performed, and I would like you to explain why there has been a reduction.

Ms Buffinton: As you know, we have an agreement with the states. There is certainly no intention of a reduction or hold up in assessments during that period. As you know, they are demand-driven, so that would depend. I would have to take it on notice. Whether there have been reassessments—certainly from 2015-16 we did see that with the introduction of regional assessment services there has been a small flow to regional assessment services rather than to ACATs.

Senator POLLEY: As we are very short on time, could you take on notice to break it down by states, as there has been a reduction. Can you explain to me, then, why I have been contacted by a constituent in northern Tasmania who has been waiting four months for an ACAT assessment? I can go through all the other states that we have information on where people are waiting up to 6 months for an ACAT assessment, which seems to me to be extraordinary.

Ms Buffinton: We have an agreement with the states. We have a KPI with the states, as you are aware, that we have three levels of assessment: high priority—

Senator POLLEY: I am aware of that.

Ms Buffinton: where the contact needs be made within 48 hours; medium contact, which is within 14 days; and low priority, which is within in 36 days.

Senator POLLEY: We are actually aware of that, but you are not explaining to me why people are actually waiting four months. If you cannot answer that, maybe you can tell me which states are actually meeting their KPIs, if that is a bit easier?

Dr McCarthy: Of course, the waiting times for individuals will always vary, and it will depend on need and it will depend on the capacity of the particular ACAT. We are able to let you know that from 1 July to 31 December across all priorities and in all settings some 80 per cent of comprehensive assessments were completed by ACATs within 34 calendar days from the time of referral from My Aged Care. I am not disputing that there may be individuals who have waited longer than that, but I am just giving you a system-wide view.

Senator POLLEY: That is not the question. The question is: why are people having to wait six months for an ACAT assessment and which ACAT teams are actually making their KPIs? It is an extraordinary amount of time. Which states? If you have people being assessed within 35 days, which states are doing that and why are Tasmania, South Australia and Western Sydney times blowing out?

Ms Buffinton: As far as meeting KPIs, which is 90 per cent making contact within the time period, to the end of the year we had most states meeting their KPIs for medium priority and low priority but we only had two states meeting their KPIs for high priority.

Senator POLLEY: Only two states are meeting the high priority? Who are they?

Ms Buffinton: That is Western Australia and the ACT.

Senator POLLEY: Why is Western Australia meeting theirs and somewhere like Tasmania is not?

Ms Buffinton: This is where, when we get our annual meeting with the ACATs in April—so we have just been writing to them about their KPIs and making them aware of their KPIs. We will have to understand locally, as you know. We have set the KPIs, but the states themselves are the ones who are prioritising their ACAT teams.

Dr McCarthy: In that meeting, we will need to raise with them these issues of KPIs not being met.

Senator POLLEY: Do there need to be more ACAT teams funded? Is the issue that there are not enough people doing the assessments?

Ms Buffinton: In the first half of last year, when we were switching from our old IT system to the new IT system—and, as you are aware, the national assessment form—we did go through a period of lower productivity. That has been climbing back through the second half of last year. As people got used to the new system, we have had a growth in both quarters as each state climbed back up towards their KPI.

Senator POLLEY: Perhaps it might be easier and a little bit faster if I put the rest of my questions in relation to this on notice. We certainly will be following up. But nothing that you have said here today actually explains why people are waiting with very severe needs for six

months in this country. I will now move on to homes and support care. How many new home care providers have been accredited that did not previously have an allocation?

Ms Buffinton: There are 72 at this stage.

Senator POLLEY: How many providers have registered?

Mr Laffan: In relation to the number of approvals for home care providers to 31 December, there were 72 approved by the department, and about half of those already provided some other form of aged care. A portion of those were residential care and some of them were providers in the Commonwealth Home Support Program.

Senator POLLEY: What was the average maximum exit fee?

Ms Buffinton: As far as those that have submitted exit fees, there are 419—or, 83 per cent of approved providers have advised as of 26 February. The average exit amount is \$417.

Senator POLLEY: How is the government monitoring the application of the exit fees?

Ms Buffinton: As far as the exit fees, in working with our co-designers we developed home care in our home care advisory group. The sector was aware that we were moving to a market, so although we will be observing and we will be publishing in order to make it transparent to the market—to that extent we are monitoring—

Senator POLLEY: Where would it be published?

Ms Buffinton: On My Aged Care. When you look in the service finder at individual providers you will be able to see their exit fees. We will also be publishing just the high-level figures, which are the number who have provided exit amounts, the average exit amounts and the range of exit amounts.

Senator POLLEY: I know this is very new, but how many of the home care package holders have changed providers since Monday?

Ms McQueen: At this point, we do not know the answer to that. We need to wait to be able to interrogate the system. As you can appreciate, the first two days have been about providers and consumers exploring the service finder and the new system to basically understand what providers are available and what their services are.

Senator POLLEY: What is the framework that you have put in place to evaluate these reforms?

Ms McQueen: With this this new program, we have turned it to become a consumer-centric focused home care delivery program. We are very conscious about making sure we monitor for any gaps. We have a national prioritisation system and with that we will be carefully monitoring where any potential gaps are over the next three to six months and that will shape, obviously, what the release of packages will be in the future.

Senator POLLEY: How well did the web page handle the transition on Monday? It was down for a while, I believe.

Ms Buffinton: No, in fact it was not. There was some slowness to the web page. We knew and that is why we were very open this time. We did learn from our My Aged Care experience in 2015. We did explain to providers one of the things we learnt was many providers observed things on the first couple of days in July 2015, and all rang in at once to tell us what was the problem with the website. This time, we said if we got any problems we

will be putting up a notice, which we did. We actually had very few issues on Monday and Tuesday.

Senator POLLEY: That is good.

Ms Buffinton: Just so you know, we did have a small browser problem. One brand of browser was not working effectively but a fix was put in on Monday night. So to that extent the system has worked throughout. It slowed down for a number of hours on Monday but it has never gone down and, by Tuesday, it was back up.

Senator POLLEY: The lag time for the ACAT assessment is unacceptable, I would suggest. People are waiting for packages to then access providers. How long is it going to take them to access a provider once they are finally assessed?

Dr McCarthy: That is going to vary. The national prioritisation system will determine the allocation of packages based on a combination of the person's need and for how long they have been waiting so it will very much depend on the individual's assessment.

Ms McQueen: The process is that the date of approval of their ACAT is the date that determines their need to wait in the queue. So they go through an ACAT assessment, have an identified level of need and a service plan is developed. Once the delegate has signed off that date, that is the date that determines where they sit on the national prioritisation system.

Senator POLLEY: Do we know how many un-allocated packages are in the central pool?

Ms McQueen: Yes. As of 30 June 2016, there were 78,956 packages allocated that were operational. Those that were currently occupied as of 30 June 2016 were 64,069 packages.

Senator POLLEY: How many people are currently waitlisted for the packages?

Ms McQueen: We are in the process of determining that. Obviously we have got two days and, hopefully, by the end of the week we will have a clearer sense about where we are at.

Ms Buffinton: To find out how long it is going to be, understanding exactly how many are waiting, will actually take a little bit longer than that. In the past, it was opaque to us as well because individual providers had those waitlists when the places were assigned to individual providers. That is what is great about this new system but it is going to take time for us to build the data. That is one of the things the government has said that will be known publicly. It will also be published to help the market operate so that providers will be able to see where the demand is so that they can respond on market-driven forces to provide supply.

Senator POLLEY: I am going to be cut off so I will put the rest on notice.

Senator SIEWERT: I will be putting lots of questions on notice. I want to go to better access to mental health, the issue that has been causing a lot of concern. First off, I think it is probably best for you to outline just what is accessible to a person in residential care in terms of better access but also in other mental health funding or programs.

Mr Cormack: Just in relation to that, I think the simple answer is that, due to an interpretation that has been relatively longstanding, residents or persons living in residential aged care are not currently accessing the better access arrangements. So that is the simple answer to your question. The background to that is that when the arrangements were established in 2006, under the regulations that applied, section 2.20.6(2) of the Health Insurance (General Medical Services Table) Regulations specifies the eligibility for better access services, including being a patient in the community. The interpretation back in 2006

was that a person living in residential aged did not meet that criterion. I guess what we are saying is that a lot has moved on in the aged-care world, and there are others who can talk more fully about that than I, but it is clear that, as we are with many of the MBS items—and we heard a bit today about the MBS review process—we are having a close look at all of this and we will be providing some further advice to government around the continued appropriateness and relevance of that provision and the way it has been interpreted historically. It has been a consistent interpretation since 2006.

Senator SIEWERT: When you say 'consistent', do you mean for this program or across the board for programs, because it is not GPs, for example, is it?

Mr Cormack: It is for the whole basket of items under the mental health better access.

Senator SIEWERT: That is why I want to be clear. It is just for better access?

Mr Cormack: That is right.

Senator SIEWERT: Who made that determination?

Mr Cormack: I do not know who made the determination.

Dr McCarthy: Mists of time, I think.

Mr Cormack: It is 11 years ago. It has been consistently adhered to. As I said, I think the world has moved on. We have review processes in place through the MBS review, plus so much has happened in the aged-care space that the matter is clearly a matter for significant review, and we will be providing some advice to government about that.

Senator SIEWERT: Okay. Can you remind me of the end date for the MBS review.

Mr Bowles: There isn't one.

Senator SIEWERT: Okay. Are you looking at things and then making some decisions through that process?

Mr Bowles: Yes. Some decisions have already been made.

Senator SIEWERT: Thank you. What priority has been placed on this to get this done and fixed?

Mr Cormack: It is a lot of priorities that we have to attend to. I am probably not the best person to answer the question about where it stands in the overall MBS review process priority list.

Senator SIEWERT: Perhaps, Mr Bowles—

Mr Bowles: It is an issue that is only just gaining a little bit of momentum at the moment, because the mists of time, I think, have hidden this for a period of time. It is definitely something that we are very aware of and want to deal with. I cannot give you an exact time at the moment on that, but it is one of those issues.

Senator SIEWERT: In the meantime, what is being done to enable people in residential care to get access to mental health care?

Mr Cormack: Again, I would have to defer to my colleague about what arrangements are in place for the range of care needs within a residential aged-care facility, but I can say that at this stage, until that review process is undertaken and governments have the opportunity to consider that, we would not be in a position to make any changes to that. It requires a policy decision of government.

Senator SIEWERT: What are the programs that could be made available if there were a will from government?

Mr Cormack: There are some similar items available under the chronic disease management Medicare Benefits Schedule items. They provide less fulsome access to a range of allied health services, including those services provided by psychologists, mental health workers and occupational therapists. In fact, they are already available at the moment. They are under a different grouping of MBS items. They are available, but, just to be clear, they are not as fulsome—there are not the same number of annual sessions available. I think it is reasonable in the circumstances we are in. It is available to people in residential aged-care facilities.

Senator SIEWERT: I understand the review, but, in order to put even a temporary fix in that provides better access to services than what we have just talked about, what has to be done to make that happen in terms of process? Surely you could do it via a change to regulation.

Mr Bowles: I would have to take some advice on that. But clearly it is a policy decision of government to do it, so we are working on that at the moment through this review mechanism that Mr Cormack talked about.

Senator SIEWERT: But that is the general MBS review. I am asking if it is possible to elevate it and fix it in the short term while you carry out the review to ensure that people in residential care are no longer classed as 'patients'? Surely that is something you could fix fairly easily through either a delegated instrument or a policy decision by government to change that definition of 'patient', given that we have all agreed things have moved on and it is not contemporary anymore.

Mr Bowles: I am happy to take it on notice to see what we can do. I do not have the answer here. Again, I cannot make that decision.

Senator SIEWERT: So no-one has asked yet look at how we solve this issue in both the short and long term?

Mr Cormack: We have just indicated to you that we recognise that there is an issue here. It is an issue of longstanding. It was predicated on a previous policy decision. We are seeking to have a look at that. We will take some advice to government. Currently like items are available under the chronic disease management Medicare Benefits Schedule.

Senator SIEWERT: Mr Cormack, I have taken that on board. I understand that the review is happening but you have also told me that there is no end date for that and it is going to take a while. I am looking for a short-term fix. Is it possible to do either a short-term fix or prioritise fixing this much more quickly given the circumstances?

Mr Bowles: As Mr Cormack said, there are some items available. That is fine. We can deal with that. I will take the rest on notice because I do not have the answer right here right now.

Senator SIEWERT: Minister, has this been raised with you?

Senator Nash: Not with me.

Senator SIEWERT: I want to ask some questions on the home care space. In relation to providers having to advise clients, do they provide information on cost per hour and the administrative costs they charge?

Dr McCarthy: Under consumer directed care?

Senator SIEWERT: Sorry, I beg your pardon. I was automatically there. Yes.

Dr McCarthy: Under consumer directed care, yes, information has to be provided to the consumer I think monthly.

Ms McQueen: There is a statement that providers under the act are required to provide all—

Senator SIEWERT: Sorry, I jumped ahead. I should have been clear. I meant before people make the decision, to help them make a decision.

Dr McCarthy: So the service finders on My Aged Care have information about the costs of the services.

Ms McQueen: We went through a lot of consultation with real consumers to make sure that the service finder would meet their needs. The mandatory component of a service finder is that they have to list what their exit fee is, but there are many other components of a service finder—for example, there is an opportunity for them to identify the percentage of admin costs as part of their package. There is quite a broad range available to each service provider to essentially advertise their service—to identify what they are specialising in so that the consumer is very much informed. There is also an opportunity for providers to put a direct link back to their own website, where people can get more detail. In terms of your original question of the monthly statement that goes out: yes, they need to be detailed with the costs that were incurred throughout that previous month of the itemised different services. There is an administrative cost usually, not always, that is also listed in that.

Senator SIEWERT: Usually, but not always?

Ms McQueen: It depends. Some providers choose not to be specific about an administrative cost.

Senator SIEWERT: That was my point. Why aren't they required to put that in?

Ms McQueen: How they price their range of services is up to each provider. Some of them do want to specifically separate out administrative costs, for example. Others roll it into the costs of their particular services.

Senator SIEWERT: I am getting the wind up.

Ms Buffinton: Since the 27th, we are trying to educate consumers—we are putting a lot of material out and we have been working with COTA for the last two years—on what to ask before you make a selection. We have a lot of checklists and a lot of support material to help them and their advocates or families to inquire and understand—

CHAIR: Sorry, Ms Buffinton, because we are short on time, I am going to go back to Senator Polley now.

Senator POLLEY: I just want to follow-up on the mental health issues. Back in 2012, the Australian Institute of Health and Welfare found that more than half of all permanent aged-care residents had mild, moderate or major symptoms of depression. I think at that time this

figure was fairly conservative. Have you got any updated data as to how many residential older Australians living in aged-care homes have mild or other mental health issues, particularly around depression?

Dr McCarthy: We would have to take that on notice.

Senator POLLEY: I will ask a very quick question in relation to the national dementia strategy. Minister Wyatt stated in parliament on 16 February of this year that the government announced the first national strategy for dementia in 2015. Because there is no reference of it anywhere, can you provide a copy of this strategy?

Dr McCarthy: Minister Wyatt was referring to the Council of Australian Governments' national framework on dementia, which I think we have discussed in this forum before.

Senator POLLEY: Can you table the implementation strategy for that minister's reference please?

Ms Rule: We can take that on notice and table the documents.

Senator POLLEY: You cannot table it now?

Ms Rule: No; I have not got it with me.

Senator POLLEY: Can you get it to us tonight?

Ms Rule: I can try, but it is unlikely. I do not have people in the office right now.

Senator POLLEY: It is too late. Sorry, it is after hours.

Ms Rule: We can take that on notice.

Senator Nash: It is always worth asking.

Senator POLLEY: That's right! Alzheimer's Australia recently renewed their call for a national dementia strategy, similar to the commitment that the Labor Party made at the last election. Now, in response to their very recent release of the *Economic cost of dementia in Australia 2016-2056* report, can you tell me what the government's position is?

Dr McCarthy: We are aware of Alzheimer's Australia's called for a strategy. The *National Framework for Action on Dementia*, the Council of Australian Government's document, actually outlines seven priority areas that broadly cover the areas that Alzheimer's Australia is also asking to be covered in a national strategy.

Senator POLLEY: When will we see that national strategy?

Dr McCarthy: It is a decision for government as to how government responds to calls from peak bodies for any particular initiatives.

Senator POLLEY: So you have not been given any information? A decision is not imminent? No, okay. When we were talking about the 2016 aged-care approval round, on 23 February of this year the government announced successful applicants to provide 475 places in the Short-Term Restorative Care program, the STRC. Funding for 400 of these places was to flow from 1 July 2016. What was the reason for this significant delay in allocating these places?

Ms Rule: There wasn't a delay. We worked with the sector to co-design the program and then when we opened the applications for funding there was significant interest. We took the time that we needed to assess those applications and the minister has made the announcement about the allocation of those places just recently.

Senator POLLEY: So it took six months, and you do not call that a delay? In fact, it is more like eight months.

Ms Rule: No.

Senator POLLEY: Can you explain how the distribution of the STRC places was determined?

Ms Rule: The places were allocated through the same process we use for the aged-care approvals round, the ACAR. We do a range of things, including consultation with the sector about their views of priorities. We look at a range of datasets to inform where areas of need and priorities might be. The thinking around how those are targeted is on the public record as part of the opening of the approvals round.

Senator POLLEY: Who made the final decisions about the allocation?

Ms Rule: The delegation for that sits within the department.

Senator POLLEY: It wasn't the assistant minister at that time?

Ms Rule: No, it was not.

Senator POLLEY: That decision is firmly made by the department—

Dr McCarthy: The aged-care approvals round is always a departmental decision.

Senator POLLEY: Without any influence of government?

Dr McCarthy: Yes.

Senator POLLEY: With only 8.3 per cent of Australians aged 65 and older who live in Western Australia, 17.5 per cent of the STRC places were allocated to Western Australia. Can you explain why this occurred? It seems Western Australia is doing very well at the moment.

Senator REYNOLDS: Because we are great.

Senator POLLEY: I know you are great, but your older Australians are not any more in need than they are in the rest of the country.

Ms Rule: I do not have data to that effect in front of me.

Senator REYNOLDS: I can probably tell you. We have 500,000 people in Western Australia; more than the population of Tasmania.

CHAIR: Order.

Senator POLLEY: This is very important data. You have come before us not expecting any questions again on this area?

Dr McCarthy: I am sorry, that is not a figure that we have in front of us. Before we can answer any questions, we would need to verify that.

Senator POLLEY: Okay. While 33.4 per cent of Australians aged 65 and older live in New South Wales, only 21 per cent of the STRC places were allocated. There seems to be some significant difference about how this has been allocated. If you cannot explain it tonight then you will take on notice.

Ms Rule: We can take it on notice. As I said at the beginning, the process that underpins the allocation of these places is based on data and is based on consultation with the sector about areas of need, and that applied to this program as well as the broader aged-care assessment round.

Dr McCarthy: We need to check the information that you have provided. One of the things that we would take into account in a round like this is the range of aged-care options available in a particular area. It may be that areas which did not receive places in proportion to their population may already have a range of care options available. But we will need to check the data that you have provided and come back to you.

Senator POLLEY: In the fullness of time—am I going to get a second bite or can I keep going?

CHAIR: Keep going for now; you have got some more time, Senator Polley, and then we will move to Senator Reynolds.

Senator POLLEY: Residential and flexible care—have we got the right people here for that? Excellent. Deloitte was awarded a \$366,700 contract to provide analysis of unmet demand and the potential implications of uncapping supply in aged care. Will that report be made public, and when will it be released? I understand that it is due in June this year.

Dr McCarthy: That report was commissioned to assist the legislated review of aged care. As you know, Mr David Tune is conducting the legislated review under the Living Longer Living Better arrangements. One of his terms of reference relates to the state of unmet demands, so that report from Deloitte will be one piece of information that Mr Tune will be accessing in order to come to his conclusions.

Senator POLLEY: You would be aware then—and I am pleased to hear that; it saves me one question—that the data on unmet demand, being the elapsed time between assessment for services and entry into aged care, has been broadly criticised by the sector as being insufficient. Do you agree?

Dr McCarthy: One of the reasons that we have commissioned this work—and I am sure one of the reasons that one of the terms of reference was around unmet demand—is that the elapsed time between the assessment and when a consumer chooses to enter either home care or residential care is only a proxy. So, for example, people may choose not to enter care or they may choose to enter care for whatever reason some time after they have received their assessment. So not everybody who gets an ACAT assessment intends to enter care immediately.

Senator POLLEY: Can you then explain to the committee what the department, or the government, are doing to improve the collection of that data around unmet needs. Do you see that there is a need to change your processes?

Dr Hartland: I think with a big program like aged care, it is always sensible to have a look at a number of sources of data. Elapsed time has been a traditional metric that has been published quite extensively. I do not think there is much value in collecting more information about that, but it is available through the AIHW. As Dr McCarthy says: it is, at best, a proxy for demand—it is really a proxy for how many people want to queue at existing doors. We are interested in the context of the review of understanding more about demand and doing that more systemically, but there is also a history with these studies. They are quite complex and sometimes they give you results that are not very helpful. In the past there have been studies of demand that have ranged from a few thousand to a few hundred thousand.

Senator POLLEY: We are a bit short of time—sorry; could I take it then that you are looking at the collection of data and how that can be improved.

Dr Hartland: Yes.

Senator POLLEY: Why was the project put out to tender and not undertaken by the department? Why are we spending \$366,700 on tendering that? Wouldn't it normally be expected that the department could undertake that?

Dr Hartland: No. I think we do collect figures on demand such as elapsed time, so we really wanted people who were fresh to the system and had different ideas to look at different methodologies for testing what is the underlying demand for aged care in a way that we would not necessarily see as program managers. So it was about getting different perspectives, and these studies are quite complex. They involve looking at, for example, population surveys, like the survey of disability and ageing.

Senator POLLEY: So the expertise is not within the department? Is that what you are telling me?

Dr Hartland: We have a lot of expertise, but we do not necessarily employ statisticians that have expertise on sampling methodology, so we need to buy in some of that.

Senator POLLEY: Can you then provide to the committee details about any other external tenders that have been awarded in 2016 and what the total cost of those were?

Dr Hartland: They are routinely published and made available on AusTender.

Senator POLLEY: But can't you just give us that information?

Dr McCarthy: We can take that on notice.

Dr Hartland: We can take it on notice, if you wish.

Senator POLLEY: You will take it on notice—you cannot tell me now. In November you were awarded a contract for more than half a million dollars to undertake a review of residential aged-care legislation. What is the purpose of this report?

Dr Hartland: That is a report that is being conducted into how we do prudential monitoring. Anticipating your next question, to save time, the reason why we commissioned that report and did not do it in-house is, again, that is an area of expertise about how you understand risk in commercial entities, how you think about balance sheets and what you might do to minimise risk. There was benefit in getting an external provider to look at.

Senator POLLEY: Does the department not have a good understanding of the legislation that governs residential aged care?

Dr Hartland: I think the title of that study might have been less than fully perfect. That study did look at the legislation and the legislative elements that go to the current management of risk, but what it was really looking at was: what do you need to know about a provider to know that they are at risk of not meeting their financial duties? The point about getting someone external was not that they knew the legislation better than us—I certainly agree that we should know the legislation better than anyone. But, we do not know commercial law and we do not know balance sheets better than everyone. We do have some expertise in that area, but, again, we wanted a firm that was expert in understanding business flows and business structures to help us understand where our legislation should target controlling risk.

Senator POLLEY: That is supposed to be reported this month—in March. Is that going to be released publicly as well?

Mr Laffan: That is due to report in April 2017. It will be taken at the same time as the review of the accommodation payment bond guarantee scheme that is being undertaken by the Aged Care Financing Authority. Both of those reports will feed into the legislative review being conducted by Mr Tune.

Senator POLLEY: I was of the understanding that this report into the review of residential aged-care legislation was to be released in March.

Dr McCarthy: I do not know that we have ever committed to public release at a certain time.

Mr Laffan: No, we have not.

Dr McCarthy: Are you referring to the due date for the deliverable to the department?

Senator POLLEY: Yes. I assumed that once you had it then it would have been made public and that it was supposed to be reported back to the department this month.

Dr McCarthy: There is a difference between when a report is due to the department and whether and when the report is made public. As Mr Laffan has indicated, that is, again, another source of information for Mr Tune to draw on in his legislative review.

Senator REYNOLDS: Good evening, again, Secretary and Dr McCarthy. The issue I want to briefly raise here tonight with you is one that I will also be raising with DSS and the NDIA, which is an issue that has been raised a lot. Are you aware of the issue—I am sure you are—that there are roughly about 5,200—

Dr Hartland: There are about 6,000.

Senator REYNOLDS: Sorry, I had 5,200. There are roughly around about 6,000 younger Australians with disabilities living permanently in aged care. This is something that this committee did an inquiry into and reported on two years ago. The report that came back was quite a disappointment because it basically said, 'Too hard, too hard, too hard, too hard.' To me, this is an issue that falls completely between jurisdictional boundaries. There is an element of aged care, there is an element of health and there is an element in DSS and the NDIA. No-one is actually accountable for the outcomes for any of these 5,200 younger Australians in terms of getting them out. What I wanted to know is what numbers you have. I got from DSS at the last estimates 5,200 and a breakdown by state. So I am just wondering if you can give us a brief on what you know about this group of younger Australians. They end up there because, out of good intentions, the Commonwealth provides them an ACAT, but unfortunately the hard truth is that states and territories have absolutely no incentive anymore to do anything for these young people because now the Commonwealth taxpayer is paying. So can you give us that, on notice perhaps, because I have to wind up.

Dr Hartland: I do want to actually clarify one matter in relation to this group. The Commonwealth does not pay for these groups. We provide a place in aged care and we then bill the states and territories for that place, so the states pay 100 per cent of their costs back to us. So at the moment, other things being equal, the states do have an incentive to find ways of getting them out of aged care.

Senator REYNOLDS: As I understand it, they get a pension. When they actually come off any disability support payments they are getting they get a pension, and 85 per cent goes through to the home. Those who are under state care get almost all of that taken off to manage

their affairs. So their pension goes or their pension is a lot less because they are now getting aged pension rather than anything else. So a lot of them are \$1,000 or so worse off a month. I know you are squinting at me, Dr Hartland, but that is absolutely the fact.

Dr Hartland: What is causing them to be \$1,000 worse off a month? I have lost track.

Senator REYNOLDS: Maybe we can take this offline. They go from disability support pension and other payments, and when they go into aged care they actually go onto a pension. The home takes 85 per cent of their pension.

Dr Hartland: That is right. Everybody in aged care is liable to pay a basic daily fee, and that is calculated at 85 per cent of the pension.

Senator REYNOLDS: And it is the taxpayer paying their pension which goes to the 85 per cent.

Dr Hartland: By far the majority of the costs are—

Senator REYNOLDS: But in the state system they do not get anymore the health and the rehabilitation support that they should be getting for their, generally, multiple conditions. They have no way out.

Dr Hartland: That is right.

Senator REYNOLDS: We can take this offline. I will raise it more with DSS tomorrow, but could you have a look at the issues because I have a lot of questions for them.

Dr Hartland: I know that time is short and the committee will not necessary appreciate a long, narrative answer. I do feel a need to say that we are actually working quite closely with DSS and the NDIA on this. Health has recently issued some fact sheets that we hope will give some guidance to providers, people who are in residential aged care, younger people in residential aged care and ACAT assessors so that they understand what is happening now for both people who are in NDIS areas and people who are not in NDIS areas. Ultimately, this will be a matter that the NDIS will be accountable to fix. As you know, there are two things about this, when you talk to DSS. Obviously, NDIS is not rolled out in all areas, so there are still people who will need to maintain access to aged care if they are not in the NDIS rollout. The arrangements for NDIS areas are complex.

Senator REYNOLDS: Can I just stop you there. Dr Hartland, that is actually not true. The NDIA advised us at the last estimates it is going to take two or three years to even register and enrol these current groups. Only 10 per cent currently have been picked up by the NDIS. There is no accommodation for them to go to. So for the next three years the majority of them will not get the disability support they need and they will not get onto their pathway to accommodation, which does not yet exist. So the fact is that aged-care facilities, without some remedial action, is going to have this population of people for three to five years. I can take this offline with you. My question is: what more can we do?

Dr Hartland: We would be happy to come and brief you on that.

[22:04]

CHAIR: Thanks very much. We will now move to outcome 5, on regulation, safety and protection, and to program 5.1, on protecting the health and safety of the community through regulation.

Mr Bowles: Chair, while they are coming to the table, may I make a quick statement? First of all, Senator Siewert earlier on was talking about Partners in Recovery and Day to Day Living. You were looking for the 2013-14 numbers, and I can give you those now if you want them, Senator. Partners in Recovery is \$84.3 million and Day to Day Living is \$14.3 million. So that completes that series of numbers. I believe I also need to clarify a couple of inaccuracies in some of the public commentary today out of something that I was asked this morning relating to the continuous glucose monitoring. It has been suggested that we are totally unaware of election commitments. That statement has been made a few times. I want to clarify that that is not the case. When we were shown the document, that referred to a costing document as opposed to the policy document, which Senator Smith rightly pointed out. I want to reiterate to the committee the answer I gave this morning: we are fully aware of election commitments, we are fully aware of the issues and we are working to the earliest possible time frame within all of the issues that have to be dealt with in line with the government's policy. We have been working with key stakeholder groups like Diabetes Australia, who have publicly stated that they fully support the timing and the approach that we have taken. I want that to be on the record, given some criticism that I feel did not reflect what was in our conversation this morning.

Senator KAKOSCHKE-MOORE: I have some questions about medicinal marijuana. I would like to begin by finding out in which states and territories are doctors currently authorised to prescribe medicinal marijuana, and how many of these doctors there are.

Dr Skerritt: Thank you for your question. Doctors have prescribed, and Special Access Scheme Category B approval has been given for, medicinal cannabis in every state of Australia. There have been no complete approved requests in the ACT and Northern Territory, but in every other state and territory, including Tasmania—

Senator KAKOSCHKE-MOORE: It is possible for a doctor to request?

Dr Skerritt: It is possible for a doctor to request it in every part of Australia, including the territories. We react to requests. For example, I think there are only one or two from Tasmania who have done it, because that is how many requests we have had. We have granted every completely filled out application. We have not rejected one. Completely filled out applications have been granted. Some have been withdrawn when we asked questions like, 'Tell us more about the condition or what the product is,' but, when complete, applications have been granted.

Senator KAKOSCHKE-MOORE: You have just answered about two more of my questions in that, so thank you. Can you explain for me what the application process is for a doctor in order to obtain approval? Whom do they need to talk to? What departments or agencies?

Dr Skerritt: As a consequence of federation, doctors have to apply to the state or territory that they are in. The requirements differ by state and territory, and that is something the Commonwealth cannot control, much as we would sometimes like to. They also have to apply to the Therapeutic Goods Administration. That is in the case for individual patients who have applications under the Special Access Scheme. An Authorised Prescriber can apply for a whole group of patients, even 100 or more. That is a much more streamlined scheme. I should read a correction in *Hansard*: I think I said this morning we had 23 Authorised Prescribers, and I think we are now up to 24. We would very much like more doctors to use that pathway,

because it then enables that clinician to provide the medicine to a wider group of patients under their care without having to request on a patient-by-patient basis.

Senator KAKOSCHKE-MOORE: What are you doing to encourage more doctors to come forward to become an approved prescriber?

Dr Skerritt: We are working closely with a lot of the clinical colleges, and also some patient groups, to improve education and information about the knowledge base on medicinal cannabis. It is fair to say that the knowledge base is mixed compared with a lot of other medicines, and that is because research has not been possible for many years in countries like the US, because of their federal bans. But we have also commissioned a major piece of work from three universities in Australia to look at the evidence base, both here in Australia and overseas. For example, two weeks ago in Sydney we had a meeting of almost 50 people—largely clinicians, patient groups and state and territory representatives—looking at the evidence and talking about the next steps that are to be carried out to make sure the knowledge base is broader.

Senator KAKOSCHKE-MOORE: What is the process for patients to get approval in order to be prescribed?

Dr Skerritt: As for every medicine, they must have a discussion with their doctor. It is the same as with any other medicine. If their doctor feels it is appropriate, there is a short form available on our website. Doctors are quite familiar with the Special Access Scheme, because Special Access Scheme B is used for over 18,000 prescriptions per year. This is not some obscure scheme. They apply both to us and through their state system. As I said, every state system does vary a bit. Another thing that came out of the meeting two weeks ago was that a lot of the state representatives realised that there really is a need to try to streamline the state schemes and, where possible, to enable, for example, simultaneous application and so forth. So a lot of them are going back to their states and talking to their directors-general and ministers about that.

Senator KAKOSCHKE-MOORE: Is the Commonwealth playing a leadership role in assisting that streamlining?

Dr Skerritt: We are playing a coordination role, but it is always important for the Commonwealth, in any Commonwealth-state thing, not to be Big Brother. It is better for us to bring the states and territories together to allow them to reach a view that it is important to iron out wrinkles in a system. I understand that a number of state ministers are going to talk about this at the next COAG health ministerial council.

Senator CAROL BROWN: How long does that process take?

Dr Skerritt: For the states and territories it varies.

Senator CAROL BROWN: No, I mean how long does it take from the doctor filling in your form and sending it?

Dr Skerritt: To us?

Senator CAROL BROWN: Yes.

Dr Skerritt: Our average time over the last 12 months has been 6.4 days. Our average time over the last two months has been between 2 days and 3 days—so 48 hours or less.

Senator DI NATALE: Can I summarise that just to get some clarity? There are two options. You can either be an authorised prescriber or you can apply through the Special Access Scheme.

Dr Skerritt: Correct.

Senator DI NATALE: Again, just so we are clear: if you are an authorised prescriber, you have approval to prescribe medicinal cannabis and you can provide it for a block of patients. You do not have to apply for individual patients each time.

Dr Skerritt: Correct, except that the approval is given for a particular type of indication. It might, for example, be for people in palliative care or it might be for people with drug resistant pain or whatever.

Senator DI NATALE: You have 24 authorised prescribers in the country.

Dr Skerritt: I am just checking my number—yes, that is right.

Senator DI NATALE: The bulk of them would be in what specialty?

Dr Skerritt: The bulk of them at the moment are paediatric neurologists.

Senator DI NATALE: For epilepsy, yes.

Dr Skerritt: Because they are the ones who have come to us.

Senator DI NATALE: Palliative care physicians?

Dr Skerritt: I would have to check the list of specialties. I know there are not only paediatric neurologists, but that is the overwhelming bulk of them.

Senator DI NATALE: Perhaps, on notice, you can give us a list?

Dr Skerritt: Yes.

Senator DI NATALE: But 24 is a very limited number. We are talking about 24 doctors across the whole country who are authorised prescribers. So the vast bulk of people who are going to get access to medicinal cannabis are not going to get it through that pathway. They are going to get it because they go and see their doctor, who does not have to be an approved prescriber, an authorised prescriber. Let us just say you are coming in with multiple sclerosis and you have spasms—an approved indication. The doctor then applies, under the Special Access Scheme, for that particular patient to get a prescription. Is that correct?

Dr Skerritt: Remember they have to apply to us and to their state or territory.

Senator DI NATALE: You say that the time you take is six or so days.

Dr Skerritt: Coming down to two to three days for complete applications.

Senator DI NATALE: What about the states?

Dr Skerritt: That is something that is out of the Commonwealth's control. I hear very different times—

Senator DI NATALE: It is all very well for you to take two or three days, but then it takes them three months to get it through the state.

Dr Skerritt: I hear very different time lines for states, ranging from a couple of weeks to longer. But it is really something the Commonwealth cannot influence.

Senator DI NATALE: I get that, but, if you are a patient, you do not care whose fault it is. You just want to get the medication. So there is a problem with this Special Access

Scheme. I think people get confused about this, which is why I want to step through it. If you are an authorised prescriber, that is one pathway, but it is only 24 doctors. The bulk of people are going to get it through this other pathway—they just go to see their GP and their GP puts the application in. They put the application in to you. We do not have to talk about the reasons, but the Special Access Scheme is for products that have not been approved through the traditional TGA pathway. They put in their application to you and to the state jurisdiction. You guys might approve it in a few days, but the states could sit on it for days, weeks or maybe a few months. Is that correct?

Dr Skerritt: The time lines that the states take are obviously set by the states. I should correct you by also saying that some states require the prescriber to be a specialist physician; others do not have that stipulation.

Senator DI NATALE: Okay. Can you take on notice which states require that?

Dr Skerritt: Certainly. We have that information, but in the interests of time we will take it on notice.

Senator DI NATALE: Do most states allow GPs to prescribe it?

Dr Skerritt: There are a range of shades. It can be specialist only, it can be a GP having consulted with a specialist and so on. I would also mention that there is nothing so special about cannabis. There is actually quite a long list of medicines that are only approved for prescription by specialists under the Poisons Standard in Australia.

Senator DI NATALE: I want to pick you up on that: there is something special about medicinal cannabis, because you will not allow it to be accessed through Special Access Scheme category A. There are two pathways for the Special Access Scheme. There is category A, which is for terminally ill people, and then there is everybody else, which is category B. Is that correct?

Dr Skerritt: There are two pathways, although category A is a bit broader than 'terminally ill'.

Senator DI NATALE: Okay, terminally ill 'with a condition from which death is reasonably likely to occur within a matter of months, or from which premature death is reasonably likely to occur in the absence of early treatment'.

Dr Skerritt: Correct.

Senator DI NATALE: But my point is that there is nothing special about medicinal cannabis, and yet for some reason you are restricting people from getting access to it—'persons who are seriously ill with a condition from which death is reasonably likely to occur within a matter of months, or from which premature death is reasonably likely to occur in the absence of early treatment'. So my question is: if there is nothing special about medicinal cannabis, why is this the only substance that you are denying access to through that pathway?

Dr Skerritt: I meant nothing special in terms of many jurisdictions limiting to specialist prescribing. In the case of medicinal cannabis, it has never been available through SAS category A.

Senator DI NATALE: Never been available, so that is a moot point.

Dr Skerritt: Not correct, because medicinal cannabis products have been provided under the special access scheme for a decade.

Senator DI NATALE: You are talking about the nasal spray. We are talking about the products available under this scheme that have never been available. Products can be vaporised, the oils—none of those products have been available before. That is correct to say?

Dr Skerritt: They have been harder to access because of medicine scheduling in some of the states.

Senator DI NATALE: We have had this discussion before. I think it is very important to get it on the record, because it is very confusing; people do not get the different pathways. Let us put authorised prescriber status to one side, because we see there are only 24 doctors who have got that.

Dr Skerritt: So far.

Senator DI NATALE: So far—there might be more. But there is the Special Access Scheme, which is the vast bulk of people. It is how a lot of drugs that have not been approved by the TGA get into the hands of patients. You can get it through the category B pathway, which involves applying to both the state jurisdiction and the federal jurisdiction. I learnt something new today. I did not realise some states have restricted it just to specialists. But there is also this other pathway, this category A pathway, for terminally ill people, and you are not making it available through that pathway.

Dr Skerritt: The decision by government when the medicinal cannabis framework was introduced was that it would be treated like a new medicine in the context that little was known about its effects; little was known about its adverse effects. It was to be available at a high quality and with a degree of clinical oversight. There was a unanimous view from the states and territories and their health departments, who were consulted in this process, and more broadly, that it was appropriate to have a degree of clinical oversight over and above one individual prescriber, whether they be a specialist or a GP. For that reason, category A is not available.

Senator DI NATALE: Can you explain that. A patient looking at it would be looking at category A and the people who potentially need it most. Dan Haslam is a case study because he is in large part one of the reasons that we managed to move this debate forward. He was a person with terminal cancer. He had medicinal cannabis for nausea that was intractable, and he had significant benefit from it. Most people looking at this would say: hang on, the people who should get access to this are terminally ill people. Why would we be putting another barrier in front of somebody who is terminally ill? Can you explain what the issue with that is?

Dr Skerritt: As a physician, I am sure you would appreciate that people who are terminally ill deserve the best-quality care. When it is a new product with limited experience, it is just as important to get broader clinical oversight—

Senator DI NATALE: Explain the clinical oversight bit, because I do not think people get that. What are you referring to? They still have to see a doctor and the doctor has to write the script. That is clinical oversight—

Dr Skerritt: Broader clinical oversight involves peer and other clinicians—

Senator DI NATALE: So you are saying they need a specialist requirement? Is that what you are referring to?

Dr Skerritt: No, it could either be peer clinicians—for example, within Victoria there is a committee of eminent palliative care physicians, eminent neurologists et cetera, who can look at the case and say, 'I do not think that is right with that young kid with seizures,' or, 'Maybe that is not the right way to go for that person with cancer.' So it is the same way that specialist oversight is used in so many other areas of medicine.

Senator DI NATALE: Was that oversight in the special access scheme category B?

Dr Skerritt: As I mentioned to you before, in special access scheme B two things happen. A clinician from our department looks at the application, but, as I mentioned, in the states and territories they are looked at by those specialist groups.

Senator DI NATALE: When you say oversight you are saying that you are in the department and you get a form and you look at the form, because you do not have to do that with category A. Is that the main distinction?

Dr Skerritt: There are two places where there is oversight with category B. As I indicated before, the states and territories have their mechanisms and in many of those cases they involve—

Senator DI NATALE: But some of them don't. Some are just GPs.

Dr Skerritt: In most cases the states and territories have an oversight mechanism.

Senator DI NATALE: What oversight mechanism? This is actually quite important—

Dr Skerritt: For example, in Victoria it involves a group of eminent physicians in those areas.

Senator DI NATALE: But in a state with the least regulation would a GP be able to do it under category B?

Dr Skerritt: Again, in Victoria I think it is currently a specialist physician—

Senator DI NATALE: I am asking about the state with the least regulation.

Dr Skerritt: There are some states where a GP could do it, but there would still be some oversight by people expert in that condition.

Senator DI NATALE: In the way of a form through the TGA?

Dr Skerritt: Both from a form from the TGA but, as I have emphasised, the states and territories have their oversight processes, which involve clinical oversight.

Senator DI NATALE: On notice, can I ask you to provide a list of those oversight mechanisms in each state, the clinician who is able to prescribe and whether that be a GP with specialist oversight. Could I have the detail on each of those?

Dr Skerritt: Yes.

Senator DI NATALE: Then perhaps we can take that up at another time.

[22:22]

CHAIR: We will move now to program 5.3, immunisation.

Senator SINGH: Mr Bowles, earlier this morning I was asking you about Bexsero, and particularly the shortages of it, and specifically relating to the minister's response to a News Corp story in relation to the vaccine supply issue in Australia. I think you took on notice throughout the day to get back to me on whether you can guarantee supply for parents who

are relying on this vaccine to be available for their children. I want to ask you again if the department has issued updated advice to parents on the ongoing shortages of Bexsero? I might ask Dr Skerritt that question.

Dr Skerritt: Bexsero is produced by GSK. There is worldwide shortage of it, because basically demand is significantly exceeding supply. Their global CEO, Andrew Witty, actually made a public statement to that effect. So this is an issue that is happening in many countries.

We have a publicly available medicine shortage website. We work closely with the company to get regular updates on their supply and availability. GSK, unfortunately, are not confident that there will be robust supplies of this product until July this year. There will not be supply to meet full demand in Australia until July this year, unfortunately.

Senator SINGH: July?

Dr Skerritt: July is the month that we were given.

Senator SINGH: That is quite a number of months away.

Dr Skerritt: Yes. It is unfortunate, but, again, it is a global thing where demand is exceeding supply.

Senator SINGH: My question to you just a moment ago was: has the department updated parents as to this ongoing shortage of supply of Bexsero?

Dr Skerritt: Professor Murphy may have something to add, but at least from our part of the department, which is to do with registered products, on our shortages site, it goes out by RSS feed to all the clinical colleges. It goes out to many pharmacists and many clinicians, including GPs. They then spread that message to their patients and to their clients. The colleges have also had fairly significant education campaigns about vaccine shortages. No, we do not write to individual parents.

Senator SINGH: Why wouldn't you write to individual parents, considering that they would have read the minister's reassurances in those Sunday papers and would have been thinking from that—because the minister had made this personal call to GSK's Australian general manager, Anne Belcher, demanding that 'the vaccine's manufacturer boost national supply'. It all sounds pretty positive from the government in that sense, coming out in the media from the minister making this personal call. But you are telling us here tonight that national supply ain't going to be there—it is not going to be there until July, in fact—despite the minister trying to be all forthright—

Dr Skerritt: I cannot speculate on conclusions that journalists may have reached.

Senator SINGH: so why wouldn't you let parents know that it is still going to be quite a number of months before they can access this vaccine?

Dr Skerritt: I cannot comment on conclusions that journalists may have reached about availability.

Senator SINGH: No, this is not journalists; this is the minister. The minister made that call, as you know, to GSK's manager.

Dr Skerritt: I am aware he made a call, but all I am telling you is about the current supply situation as advised to us by the company.

Senator SINGH: So you are aware of the call. Why didn't the government do anything sooner? Why did it take the minister to respond because a journalist was sniffing around about the shortage—

Senator Nash: Senator, I am going to pull you up there, because it might be useful to provide a bit of information for you in terms of timing before you again assert that it was in response to the journalist. The minister spoke to the head of GSK twice. After the first conversation with GSK, a journalist was advised that the minister had spoken directly to the CEO of GSK to request that continuous supplies are available for the market: 'She has assured me that they are expecting additional supplies very shortly and will work to ensure that they meet the Australian market through the course of the year.' After the second conversation, a journalist was advised that he had again spoken with the general manager and reiterated the importance of continuous supply for the Australian market. I think it is very important that we get the facts on the record, Senator, and remove the assertion that it was in response to the journalist.

Senator SINGH: I agree; let us get the facts on the record. When did GSK inform the department that delays would be ongoing until July?

Dr Skerritt: We were informed originally of this in October. It is good to hear that there may be more supply available. I reiterate my earlier comment that there is only so much vaccine globally, and it does not meet global demand. The medicine plants that are producing this vaccine are working 24/7 rosters, according to Andrew Witty, the CEO of GSK—

Senator SINGH: That is enough, thank you.

Dr Skerritt: So 27 October was the initiation of the most recent shortage—

Senator SINGH: 27 October last year. Why did the minister tell parents via the media that he expected the shortage to be resolved 'soon'? 'Soon', to me, is not July.

Mr Bowles: That is a question for the minister.

Senator Nash: I would have to take that on notice.

Senator SINGH: Will you take that on notice?

Senator Nash: Yes.

Senator SINGH: On 12 February, News Corp reported that the minister had called GSK to request that they reinstate supply of the vaccine to Australia, and the report said that the minister only acted after inquiries by journalists.

Senator Nash: I am going to pull you up again there. I have just put the facts very clearly on the table, so I do not know why you are continuing to assert that the minister's actions were in response to the journalist. They were not.

Senator SINGH: What undertaking did GSK give the government after the minister made that call?

Senator Nash: I am not aware. I would have to take that on notice.

Senator SINGH: Professor John?

Dr Skerritt: No. We were not a party to that—

Senator SINGH: Did they guarantee supply?

Dr Skerritt: We were not there when that phone call was made, so you would have to refer it to the minister.

Senator SINGH: Was anyone there?

Dr Skerritt: The minister, presumably.

Senator Nash: The minister was on the call.

Senator SINGH: Doesn't anyone at the table know the detail of that conversation?

Dr Skerritt: No.

Senator Nash: I have indicated I will take it on notice.

Senator SINGH: My last question is: if GSK had advised the department in October that shortages would be ongoing until July, which you have stated, then why did the Prime Minister's letter say differently?

Dr Skerritt: Why did which letter?

Senator SINGH: Apparently, the Prime Minister's letter said differently.

CHAIR: The witnesses are not familiar with that letter, so if there is one there to table then that may assist them. Otherwise—

Mr Bowles: Maybe if you table that and we take it on notice—

CHAIR: That may be the best way. Would that be the best way, Senator Singh?

Senator SINGH: All right.

CHAIR: Have you concluded?

Senator SINGH: Yes.

CHAIR: That will conclude our examination of outcome 5. I understand there are no questions for outcome 1 from any senator present in the room, because Senator Watt is putting his on notice and no-one else is here who has indicated they have questions.

Senator SIEWERT: Senator Ludlam has, but he is not here. No, there he is—hang on!

[22:32]

CHAIR: I beg your pardon; we now have Senator Ludlam present. It will be a very brief bracket, of five minutes, Senator Ludlam, on the National Health and Medical Research Council, outcome 1.

Senator LUDLAM: Welcome back, Professor. We are going to have to race through these. Anything that seems more than moderately complex I would be happy for you to take on notice.

On 2 February this year, the NHMRC announced via your website that there are two proposals under consideration for targeted calls for research, TCR: tick-borne and Lyme-like illness, which this committee had a fair bit to do with last year, and myalgic encephalomyelitis or ME/chronic fatigue syndrome. Tell us what happens from here with those two proposals. Do you fund them both, or is there some triaging underway?

Prof. Kelso: It is true that we have provided a pathway for community and professional groups to nominate topics that can be considered for a targeted call for research. We have several different pathways for such topics to be brought to us and for an expert committee then to go through those proposals and prioritise them and give advice to our research

committee on whether they should be put forward for consideration as a targeted call for research. As you say, we received suggestions for targeted calls for research around ME/CFS and also Lyme-like illness in Australia. Both of those proposals have been looked at carefully and, at this stage, we need to refine them further and we are going to need to have expert advice to be able to decide whether and how they should be supported for research.

The difficulty at the moment is—and the two cases are quite similar, to the extent—that these are syndromes for which there is not a clear clinical definition, there are not clear diagnostic tests, there are not established treatments and methods for looking after patients, which is exactly why there is a need for research. But, the scope of the research that is needed to address all of those issues for both of those complex illnesses is very broad. So we are going to have to find a way to target the research so that it can be effective with the funds available. There is more work to be done and a decision has not yet been taken on whether or when those will be funded.

Senator LUDLAM: Can you tell us what your time line is forward decision making?

Prof. Kelso: We do not have a specific time line. We are working through a number of such proposals. I cannot give you a date today, but it is work for this year to decide how to progress.

Senator LUDLAM: Some of the advocates from the ME/CFS groups—one that I am aware of anyway—are actually very concerned that any delay after the next round of submissions in April may mean that these folk drop-off, so can you assure us that that is not the case and that they are still very much in consideration?

Prof. Kelso: Yes, they are still in consideration.

Senator LUDLAM: They are—thank you. In terms of the experts that you would consult, could I draw your attention to the work of this committee from last year that Senator Siewert chaired—you are, no doubt, aware of that—at which some of these experts were brought to the table. I have brought to your attention before the work of NCNED, the unit at Griffith University, who are doing superb work on diagnostic criteria for ME/CFS. Would they be among the experts that you would consult as part of this funding round? The reason that I raise that is that they are very close to diagnostic criteria. They have had some breakthroughs that have been heralded around the world.

Prof. Kelso: The full range of expertise, including those people, will be considered for forming a panel to advise us, but in that case they may well be applicants so that creates an interesting situation for us, because we would want the very best people to be able to apply for funding for support. So we have to work very carefully with conflicts of interest to ensure that those who are advising us on what should be funded are not exactly the people you want to have doing the research. But we are aware of the work that is being done at Griffith and are really delighted to hear that there is an important advance being made.

Senator LUDLAM: This is probably going to stray into the realm of questions on notice, but the other thing that I am interested in is that, as we move from diagnostics to treatment, we are going to need to skill up the nation's GPs. At the moment there is obviously a range of views in the GP committee about whether this is psychosocial rather than biomedical. What is the process for funding education programs for GPs and distributing this research that is being

done so that we can winnow out some of the frankly quite harmful treatments that have been proposed?

Prof. Kelso: Senator, that is beyond the scope of the National Health and Medical Research Council. I am not really qualified to comment on that.

Senator LUDLAM: That is fair enough. Minister or Mr Secretary, can I throw that one to you on notice, seeing that we are out of time. In the specific case of when you have got diagnostic criteria that have been identified for conditions such as this, which has been out there in the cloud for a while as very poorly understood, how do we get that information into the hands of GPs so that people are properly diagnosed?

Senator Nash: We will take that on notice.

Senator SINGH: Chair, I have this letter that I referred to in my question to Adjunct Professor John Skerritt, which is a letter from the Prime Minister to the Leader of the Opposition, which clearly states: 'I understand the current shortage is expected to cease at the end of January 2017.'

CHAIR: I think they have agreed to take the question on notice. If you table that we will accept it as a document.

Senator SINGH: I am happy to table it.

[22:39]

CHAIR: Having concluded outcome 1, we will now move to sport and recreation, finally.

Mr Bowles: Are we going to ASADA first? We have a few different bodies.

CHAIR: At the beginning of this session, I was given to understand that Mr McDevitt has a statement that he would like to make.

Mr Bowles: Yes, assuming we are starting with ASADA.

CHAIR: Let's go that way. Senator Farrell and Senator Brown, we are largely in your hands. Do you want to start with ASADA?

Senator FARRELL: I am happy to cooperate.

Australian Sports Anti-Doping Authority

CHAIR: Mr McDevitt, we understand this may be your last time with us.

Mr McDevitt: That is right.

CHAIR: I am sure you are very sad! Would you like to make an opening statement?

Mr McDevitt: Thank you, Mr Chair. Thank you for allowing me to make a short statement. I expect this will be my last appearance before this committee as CEO of ASADA. As you may be aware, my contract expires in early May and I have declined the opportunity to renew it. That said, given the calls for a Senate inquiry in recent days, I would like to make it crystal clear right now that should one be held I would make myself readily available.

Over the past couple of decades, I have had many opportunities to appear before various committees within this building. On all occasions, I have done my utmost to furnish these important committees with the most accurate and fulsome responses. I take the evidence I give at these committees very seriously. Since my last appearance before this committee, I have received the correspondence from you, Mr Chair, in which you advised me that the

committee has carefully considered allegations you received from Mr Bruce Francis and Mr Alan Hird to the effect that I may have provided this committee with false and misleading evidence. I note you state in your letter to me that this committee is satisfied after considering the allegations that in fact I have not provided the committee with false or misleading evidence. I thank the committee for its deliberation and decision on these matters.

My job as the anti-doping regulator for the past three years has been, amongst other things, to pursue allegations of possible breaches of Australia's anti-doping rules. There are many unique features of our anti-doping framework, primarily designed to ensure that, as matters progress, there are opportunities for athletes to be legally represented, to detail their case, to outline any defences to allegations and to appeal decisions made at various levels of arbitration. The critical word here is 'arbitration'. At the risk over oversimplification, sports law is essentially based on a process of arbitration and contracts.

It is also important to emphasise that Australia's response to doping in sport is not governed by the criminal law. Instead, it is largely enabled through contractual agreements between the parties, and at its heart is the globally accepted premise of an athlete's personal responsibility for what goes into their bodies. It includes a strictly defined process for the adjudication of alleged breaches which is entered into by athletes when they agree to sign a contract to play their chosen sport. For example, when Essendon players signed their contracts, they agreed to a framework of arbitration which allowed for anti-doping allegations to be heard in the first instance by the AFL Anti-Doping Tribunal and then for there to be avenues for various parties to appeal findings to higher bodies, including the AFL Anti-Doping Appeals Tribunal and/or to the Court of Arbitration for Sport.

So claims that players in this instance were tried twice for the same offence are patently false. What happened here is that the parties involved followed to the letter the agreed contractual appeal mechanisms. The arbitration procedure that all players had agreed to contained avenues for appeals by WADA to the Court of Arbitration for Sport against decisions of the AFL's own tribunals. This appeal opportunity is common to almost every contract signed by an Australian sports person, and in fact most appeals to the Court of Arbitration for Sport are actually initiated by the athletes themselves. The fact an appeal to the Court of Arbitration for Sport was lodged in the Essendon matter was certainly not a unique event in Australian sports administration and certainly not a denial of the players' rights.

This is just one example of the chasm which seems to exist between those infinitely versed in the administration of sports law, such as the numerous highly experienced teams of lawyers and barristers who represented Essendon and the players throughout these matters, and the understanding of occasionally confused onlookers who are generally more familiar with criminal law processes. One stark similarity between the criminal and anti-doping regimes is that under both there are multiple opportunities for both the merits of a particular case and the processes applied in advancing the case to be subjected to extensive scrutiny by external authorities.

We are all acutely aware that in the Essendon case both the merits of the evidence against the players itself and the manner by which some of that evidence was obtained—that is, via a joint investigation—have been canvassed thoroughly and exhaustively. Aspects of this case have been forensically examined by bodies including, but not limited to, the independent Anti-Doping Rule Violation Panel, the AFL anti-doping tribunal, the Victorian Supreme

Court, the Federal Court of Australia both by single judge and via full bench, the Court of Arbitration for Sport and even the Swiss federal court. I make this point given the recent call to arms by some for a Senate inquiry into some as yet unidentified aspects of the Essendon case. One plain fact I would put forward is the obvious point that a Senate inquiry cannot have the effect of setting aside the rulings of either the findings of lawfulness of ASADA's actions by the full bench of the Federal Court or the findings of doping violations against Essendon players by the Court of Arbitration for Sport. A second plain fact I put forward is that, so far as anti-doping matters can be litigated in this country, either on merit or on process, the Essendon matters have been finalised fully. Should members of this committee and others in this place determine that some sort of additional inquiry is necessary for some reason, I restate my willingness to participate as required. I also make the point here that I stand by every decision I have made as CEO of ASADA since my appointment in May 2014.

In closing, I remain firmly of the view that those in our community who accept that doping is a real threat to sport in our country also can see that ASADA is not the enemy and that the fight against doping is not a fight against sport. Thank you, Mr Chair, and sorry for taking so long, but I needed to put a couple of things on record given some of the recent commentary.

CHAIR: And thank you very much.

Senator FARRELL: Thank you for that statement, Mr McDevitt. If it gives you any comfort in your retirement from ASADA, the opposition is not convinced that there is any need for any further Senate inquiry, and I suspect that is also the position of the government—the minister may wish to say something about that if she chooses. I would like to thank you on behalf of the opposition for the role that you have played over the last three years.

Mr McDevitt: Thank you.

Senator FARRELL: I have a few questions in your dying days with the organisation. What are ASADA's current staffing levels and are further cuts planned?

Mr McDevitt: The average staffing level as of 30 June 2016 was 47 part- and full-time staff, and we have a number of casuals and we have sort of rolled up the time that they utilise to a full-time equivalent, which makes a total of 52 staff. Sorry, what was the second part of your question?

Senator FARRELL: Are further cuts planned?

Mr McDevitt: We have a cap on the ASL going forward of 50 positions.

Senator FARRELL: So, if you have got 52, does that mean you are over the cap at the moment?

Mr McDevitt: We will move to a cap of 50. I made the point at the last hearing when you asked the question that there has been an impact of moving to a shared services arrangement with the department. We have also had a contestability review of how we do our collections capabilities and we have streamlined that somewhat.

Ms Perdikiogiannis: I would just like to clarify something that Mr McDevitt said earlier. At 30 June 2016 our ASL was 52. At present, year to date, it is 47. However, we are undertaking recruitment action. We are reinvesting in our operational capability, so we are recruiting for a couple of new positions at the moment.

Senator FARRELL: And you will then get it back up to that 50?

Ms Perdikogiannis: That is correct.

Senator FARRELL: But it will not ever now go above 50?

Ms Perdikogiannis: Certainly, over the forward estimates, the ASL is 50.

Senator FARRELL: Mr McDevitt, last estimates you talked about staff from the Australian Federal Police and Border Force being seconded to the agency. Have there been any further structural changes to staffing?

Ms Lind: Since the last hearing we have created a new position at the executive level 2, which is a principal analyst. That position will help with our strategic assessments of the threat and risk of doping across our sports.

Senator FARRELL: Has that position been filled?

Ms Lind: We are in the process of recruiting that at the moment.

Senator FARRELL: And that is one of the three positions you are recruiting for at the moment. When are you likely to fill that position?

Ms Lind: In the next fortnight.

Senator FARRELL: That is the extent of the changes?

Ms Lind: Correct.

Senator FARRELL: ASADA's July to December 2016 file list includes a file about advice on general staffing information from the department and one about an MOU with the Australian Public Service Commission. Could you explain what that advice was and what the MOU is?

Ms Perdikogiannis: I would have to take the advice part of the question on notice. Regarding the MOU, the Public Service Commission enters into MOUs with Australian government agencies for the provision of its services. We pay an amount, which is based on our staffing level as calculated by the APSC each year, and that amount buys us a suite of services from the Australian Public Service Commission.

Senator FARRELL: Like what?

Ms Perdikogiannis: Things like training and general information provision. I do not have the MOU with me, so I cannot give you the specifics of the services.

Senator FARRELL: But you could make that available to us?

Ms Perdikogiannis: I could certainly take that on notice and make it available.

Senator FARRELL: Has the ASADA executive completed its consideration of the recommendations from the RSM review of ASADA's funding model?

Ms Perdikogiannis: The RSM review, which is the subject of the previous question on notice, has formed the basis of a submission that we have made to the Health portfolio charging review. In that context, what we are looking to do going forward is to rely on that review to form the basis of further discussions and consideration by government about ASADA's future funding.

Senator FARRELL: Is that a yes or a no?

Ms Perdikogiannis: That is a yes.

Senator FARRELL: Do you want to say a little bit more about what is happening?

Ms Perdikiogiannis: Something that we have known but that the review highlighted for us is the fact that our funding base is declining in terms of a tight fiscal environment that we are in both from government and also from sport, so we have got long-term reductions in user-pays revenues as sports invest in other competing integrity priorities. In terms of our external revenue at this point it comes from a reasonably narrow range of activities. We charge for our testing, we charge for education. Under the co-regulatory arrangements that had been determined through a previous cost-recovery review the decision was made to charge for the direct cost for the provision of those services. I think it is probably time to revisit those revenue streams.

Mr McDevitt: The long and the short of it is that these two discussion papers and reviews will now better inform ASADA to go to government with a longer term funding strategy in the way that we conduct our operations in terms of the balance between our testing services, intelligence and investigations, because we are doing the work differently now. We have additional violations to monitor. It will also look at different options and strategies for dealing with the user-pays arrangements as opposed to the government funded testing arrangements that we have. I think we are better informed now to go to government and say that these are the options for the future.

Senator FARRELL: The whole premise of the inquiry, I suppose, was to come to grips with the fact that you are dealing with a smaller amount of money to provide the same or greater level of service. Is it fair to say that?

Mr McDevitt: That is exactly right. We have come under the same sort of stress as a lot of agencies have. You have to deal with the efficiency dividend and the move to the shared services arrangements and those sorts of things, and it all has impacts on us. There is the shifting structure within the organisation and the additional violations to monitor and so on. We are doing it in as a sophisticated manner as we can.

Senator FARRELL: Was the reduction in the funding part of your personal considerations not to renew your contract?

Mr McDevitt: No, it was not, Senator. No, the ongoing funding was not an issue for me and my deliberations. I had made it very clear from the day I arrived that I would be here for three years, and I have a philosophical view that CEOs stay too long, so I have always stayed in the one job for the one contract and then moved on.

Senator FARRELL: Well, good luck in whatever you do.

Mr McDevitt: Thank you, Senator.

Senator Nash: I might just take the opportunity to wish Mr McDevitt all the very best in his future.

Mr McDevitt: Thank you, Minister, I appreciate that.

CHAIR: We echo those sentiments.

Mr McDevitt: Thank you, Chair.

CHAIR: Thank you, Mr McDevitt and all the best. We will move to the Sports Commission now.

Australian Sports Commission

[22:58]

CHAIR: Senator Farrell, if you would like to kick off. Welcome, Ms Palmer.

Senator FARRELL: Thank you, Chair, and congratulations on your new role, Ms Palmer.

Ms Palmer: Thank you.

Senator FARRELL: We, of course, have had many dealings in a previous life, a previous capacity. I hope our new dealings are as constructive as the old ones.

Ms Palmer: I have to say that it is a wonderful opportunity to be in this role and I am looking forward to working for sport in this country. It is wonderful.

Senator FARRELL: I am sure you will do a terrific job.

Ms Palmer: Thank you.

Senator FARRELL: I want to ask some questions about the former minister. As you know we have had three ministers of sport in the last four or five weeks. One of them, of course, was former Minister Sussan Ley. Are you able to tell us how many meetings, visits or other events related to the Gold Coast 2018 Commonwealth Games that the former minister attended?

Ms Palmer: No, I would have to take that question on notice. I am not aware of that.

Senator FARRELL: Is there anybody in your entourage who would happen to know that?

Mr Bowles: Sorry, what was the question? I am struggling to hear.

Senator FARRELL: My question was: how many meetings, visits or other events related to the 2018 Gold Coast Commonwealth Games did the former minister attend?

Mr Bowles: I would have to take that on notice—specifically around the Commonwealth Games?

Senator FARRELL: Yes.

Mr Bowles: There was a Commonwealth ministers' meeting I know that she did attend and I know that she did meet with officials from the Commonwealth Games, but we would have to take that on notice.

Senator FARRELL: How many of the events of that nature did the departmental or Sports Commission staff attend with the former minister, or provide advice on?

Mr Bowles: In relation to the Commonwealth Games?

Senator FARRELL: Yes.

Mr Bowles: We would have to take that on notice.

Senator FARRELL: If you can tell us how many of those events that I referred to there were actually held in the Gold Coast—events that relate to the Gold Coast Commonwealth Games and how many of them actually occurred in the Gold Coast itself.

Mr Bowles: We can take that on notice.

Senator FARRELL: Can you advise us of any basic details of the events that did occur at the Gold Coast?

Mr Bowles: No. I am not aware of any meetings at all in relation to the Commonwealth Games at the Gold Coast. As I said, I would have to take it on notice.

Senator FARRELL: So the minister went to the Gold Coast 27 times and did not do a single event?

Mr Bowles: Again, I would have to take it on notice. I was not with her on any meetings with Gold Coast Commonwealth Games events.

Senator FARRELL: How many ministerial briefs has the sports division of the department prepared and provided to the Minister for Sport since the 2016 election?

Mr Bowles: I would have to take that on notice. It would be a number, I am sure.

Senator FARRELL: How many have the ASC and ASADA each prepared and provided?

Mr Bowles: How many each at ASC and ASADA? I will take on behalf of ASADA and Kate—

Senator FARRELL: A couple of people have turned up on the table.

Mr Bowles: They are my officials, just in case.

Senator FARRELL: I thought they might have had some answers that would save you from having to answer question on notice.

Mr Bowles: No.

Senator FARRELL: I might just read these questions. It sounds like you are going to take them all on notice.

Mr Bowles: We obviously did not come prepared to talk about meetings and things like that, so I am prepared to take them on notice and work them out.

Senator FARRELL: Why wouldn't you have?

Mr Bowles: I do not manage the minister's diary, for one. It is not a departmental function.

Senator FARRELL: No, but there was a certain controversial departure of the minister—you would have expected to get some questions about it, would you not?

Mr Bowles: I expect to get questions, but I will also give the same answer. I do not manage the former minister's diary and I do not have a lot of visibility over every single thing that happens. We will take on notice and, to the best of our ability, we will come up with the answer.

Senator FARRELL: No, I think a lot of people did not have much visibility about what was going on. Again, I will read these questions and you can listen to them. I am happy to provide them to you in writing so you do not have to scribble them down. How many of those briefs were provided between the minister taking over the portfolio and the end of 2015? How many were provided between 1 January 2016 and the former minister's resignation on 13 January 2017? You may know the answer to this question: did the former minister travel overseas in her role as Minister for Sport?

Mr Bowles: Yes she did.

Senator FARRELL: Was that to attend the Rio Olympics?

Mr Bowles: The Rio Olympics.

Senator FARRELL: Who travelled with her?

Mr Bowles: I travelled with her. I cannot remember anyone else. It was in relation to the Commonwealth Sports Ministers Meeting, which was on in Rio.

Senator FARRELL: It was not for the Olympic Games?

Mr Bowles: It was both. What happens with the Olympics and the Commonwealth Games is there is a Commonwealth Sports Ministers Meeting at the Commonwealth Games and then the Olympic Games. Every two years you have the Commonwealth Sports Ministers Meeting. Then Minister Ley chaired the Commonwealth Sports Ministers Meeting in Rio prior to the Olympics starting.

Senator FARRELL: Is that because the next Commonwealth Games were going to be in Australia ?

Mr Bowles: Largely, but you can chair the meeting without having the Commonwealth Games. When then Minister for Sport Dutton, did the previous one, he said Australia would chair, and that was the process. So Minister Ley went to the Commonwealth Sports Ministers Meeting. I assisted in that process with her. I had a couple of officials with me, basically managing the chairing and the other process with her. From memory, the minister attended, I think, only the first day of the Olympics and then came home.

Senator FARRELL: Can you provide us with a breakdown of the minister's travel costs and those of the other people who—

Mr Bowles: That is a question you will have to ask Finance. Finance manage the ministerial expenses process.

Senator FARRELL: You do not have those.

Mr Bowles: I do not have any visibility at all.

Senator FARRELL: How many briefs did the department prepare and provide to the former minister regarding the relationship between the AOC president, John Coates, and the ASC chairman, John Wylie?

Mr Bowles: I am not aware. I would have to take that on notice.

Senator FARRELL: You do not happen to know, Ms Palmer?

Ms Palmer: No. I would have to take that on notice.

Mr Bowles: It would have been an issue that would have been dealt with in the department as opposed to the ASC, I believe, but I will take that on notice.

Senator FARRELL: You cannot recall anything coming across your desk about it?

Mr Bowles: I can probably recall about one piece of correspondence, but I would have to take on notice to check what else might have happened.

Senator FARRELL: When you are doing that, if you do not know the answer to this question, did the former minister at any stage meet with Mr Coates and/or Mr Wylie, either separately or together, to mediate the dispute between the two gentlemen?

Mr Bowles: I think we are jumping to an end point. Then Minister Ley would have met with John Wylie on a number of occasions. She would have met with Mr Coates as well, I am sure. In relation to any other issue about contention between the two, I am not sure there was any real contention between the two that Minister Ley would have intervened in. I am happy

to take on notice to check on if they met together. I am not aware of them ever meeting together, but, as I said, I do not manage the minister's diary. We will see what information we have.

Senator FARRELL: It was a very high profile dispute. Surely somebody in sport—

Mr Bowles: That largely happened in the last little while, as opposed to an ongoing issue.

Senator FARRELL: It was reasonably well known towards the end of the year that there was a problem. Most of the rest of the questions I will put on notice, but I did have one question regarding the Australian women's cricket team, the Southern Stars. They are performing terrifically well, but their high-performance funding has been reduced to less than \$200,000 in the latest allocation. Can anybody explain why that has happened?

Ms Palmer: I would like my colleague the Director of the AIS to respond.

Mr Favier: Under the Winning Edge approach we took post-London, we revised all of the sport categorisation framework that we used to apply the grants for sport. We also developed a set of investment principles that sit atop the sport categorisation process, and we take into account the own-source revenue of a number of sports when making investment decisions related to sport. In the case of women's cricket, I think that \$194,000 a year is the current allocation in 2015-16. That funding, as I recall, was reduced in the 2013-14 financial year from their previous allocation.

Senator FARRELL: Yes, but the question was: what is the rationale? Winning Edge is all about—

Mr Favier: It is a combination of the prioritisation of resources towards Olympic Games, Paralympic Games and Commonwealth Games, then considering the role of iconic sports such as cricket—and taking into account that we do not fund men's cricket at all; we fund women's cricket to that level to provide a contribution towards their campaign.

Senator FARRELL: But the rationale behind Winning Edge is that if you do well, you get rewarded. It seems to be the opposite for the Southern Stars.

Mr Favier: Across the priority targets—being Olympic Games, Paralympic Games and Commonwealth Games.

Senator FARRELL: Will there be further cuts to the Southern Stars?

Mr Favier: That remains to be seen, depending on where our funding allocation lands for 2017-18.

Senator FARRELL: Is there likely to be an increase, given their terrific performance?

Mr Favier: Again, it depends on our funding allocation as to how we allocate those resources once it is in line.

Senator FARRELL: When will you make that decision?

Mr Favier: The final decision would be made after the federal budget.

Senator FARRELL: There has also been a \$100,000 reduction in the participation funding to Deaf Sports. Again, can you tell us why that was?

Ms Palmer: The funding model for participation works on a similar formula, so again it is prioritising that funding based on a range of criteria. I can ask my colleague, who is the acting general manager of sport participation and sustainability.

Senator FARRELL: Why would you be taking it away from, with all due respect, Deaf Sports?

Ms Palmer: I will ask Geoff Howes to respond to that question.

Mr Howes: I am pleased to say that we are going through a process now of trying to find a way of supplementing some funding for Deaf Sports.

Senator FARRELL: Excellent news. When will you make a decision about that?

Mr Howes: Again, it is tied up in the budget process, but we are looking at it.

Senator FARRELL: So it will not be before the budget?

Mr Howes: No.

Senator FARRELL: All right. Let's hope that is what you do. I will go to my last question. You might have noticed today that both the ABC and *The Adelaide Advertiser* reported that when the Adelaide Crows, Port Power, West Coast Eagles and Fremantle Dockers play away games now, for the first time they will not be directly telecast. Does anybody at the table have a view about that?

Mr Bowles: It is the first I have heard of it, because we have been in here all day and I have not seen much on the news! But television rights with AFL clubs is not an issue we would necessarily get involved in.

Senator FARRELL: I know there are other areas, but I thought that, given the importance of Australian Rules—that quintessential Australian game—you might have had a view on it. No views?

Mr Bowles: No, Senator.

Senator Nash: I think you have a view, Senator.

Senator FARRELL: I have a very strong view, and that is that we ought to have direct telecasts. I just thought that somebody in sports might have had a view about it, but it does not look like they do.

Senator CAROL BROWN: I have some questions about the Special Olympics, and I will ask this to anyone who is at the table: are you aware that the Special Olympics closed their office in Tasmania?

Mr Howes: Yes.

Senator CAROL BROWN: Have any other offices around the country subsequently closed as well?

Mr Howes: Not that I am aware of.

Senator CAROL BROWN: Are they in danger of closing?

Mr Howes: Not that I am aware of.

Senator CAROL BROWN: What does that actually mean?

Mr Howes: The way I understand the process that has been undertaken is that Special Olympics looked at their operations and looked at their available budget and made some decisions about where they could best expend their resources.

Senator CAROL BROWN: That is sort of wrong, but anyway. Special Olympics Australia have closed the office in Tassie and they may be looking at closing other offices.

Have Special Olympics Australia been in contact with anyone at the table about receiving extra funding, some assistance or any sort of other resource?

Ms Palmer: Not to my knowledge.

Senator CAROL BROWN: Mr Howes, you seem to know something.

Mr Howes: No. There are always conversations about funding and additional resources. There have been no specific requests around this, although there have been some conversations with the Tasmanian sport and rec department about what sort of assistance can be provided in a local sense but they have not progressed any further than that.

Senator CAROL BROWN: But Special Olympics Australia have not come to you?

Mr Howes: I am not aware that they have. Can I take that on notice?

Senator CAROL BROWN: Absolutely. How much funding do they receive?

Mr Howes: I think it is in the region of \$500,000 a year.

Senator CAROL BROWN: Is that a static amount or has it increased?

Mr Howes: It has been fairly static.

Senator CAROL BROWN: You know, there are 600,000 people with an intellectual disability in Australia and there are only about 3,000 who participate. I have some concerns that the programs that are on the ground in Tasmania will not continue to operate if there is not some more assistance given. Could the minister check with the minister whether there is anyone from Special Olympics Australia or even from Special Olympics Tasmania who has put in a request for more funding—

Senator Nash: I will take that on notice.

Senator CAROL BROWN: or perhaps even put in a request for more funding to be given to make sure it is actually a nationwide organisation. Is the Australian government providing any funding to the Special Olympics World Winter Games?

Mr Bowles: Nothing from the department.

Senator CAROL BROWN: Nothing from the ASC?

Mr Howes: No.

Senator CAROL BROWN: Do you provide any funding, resourcing or any sort of assistance to the Special Olympics Australia National Games, which will be held in Adelaide in 2018?

Mr Howes: Not through the Australian Sports Commission, no.

Mr Bowles: Nothing that we are aware of.

Senator CAROL BROWN: So it is \$500,000 for 600,000 people with intellectual disability and, of that 600,000, only 3,000 are able to participate. It is not a great deal of money. We have already heard that there is a cut in funding for Deaf Sports.

Mr Howes: There are a range of different ways we actually support Special Olympics.

Senator CAROL BROWN: I asked that question.

Mr Howes: As part of the Sporting Schools program, we actually work closely with Special Olympics around providing support to special schools. There are a number of

different things that we do, including providing broader levels of support for people with disability in general.

Senator CAROL BROWN: What do you do in Tasmania?

Mr Howes: Can we take that on notice?

Senator CAROL BROWN: Yes, it would be great if you could provide what you do in Tasmania. Is there any avenue to increase the funding for Special Olympics? You said \$500,000; I think it is actually more than that.

Mr Favier: It is \$545,000.

Senator CAROL BROWN: Yes, I thought it was more than that.

Mr Howes: We look at the funding levels for all sports throughout the year. It is a question of where we can allocate the available budget.

Senator CAROL BROWN: I will put some questions on notice. You have taken on board to provide the committee with some information as to what resources and other assistance you give Special Olympics Australia, particularly in Tasmania. Could you also have a look to see if any other state or territory branches are under threat.

Mr Howes: Sure.

Senator CAROL BROWN: It is a grave situation. We hope that the Tasmanian branch will be able to be established again soon. If you do not give me the appropriate responses, I will come back and see you in May!

CHAIR: As much as I was beginning to believe we were all going to be sleeping here tonight, I think that concludes the examination of the health portfolio! I would like to thank the minister, the secretary and all the officers who spent their entire day here. I would like to thank Hansard and Broadcasting for their patience, as well as the secretariat staff. Senators are reminded that written questions on notice should be provided to the secretariat by close of business Friday, 10 March this year. The hearing is adjourned.

Committee adjourned at 23:21