Chapter 2
Health Portfolio

Department of Health

2.1 This chapter outlines the key issues examined during the committee's 2016–2017 Additional Estimates hearing for the Health portfolio.

2.2 Outcomes of the Department of Health (DOH) and entities within the Health Portfolio were called on in the following order:

- Cross Portfolio Outcomes/Corporate Matters;
- Australian Institute of Health and Welfare;
- Outcome 4: Individual Health Benefits;
- Outcome 2: Health Access and Support Services;
- Food Standards Australia and New Zealand (FSANZ);
- Outcome 6: Ageing and Aged Care;
- Outcome 5: Regulation, Safety and Protection;
- Outcome 1: Health System Policy, Design and Innovation;
- National Health and Medical Research Council (NHMRC);
- Outcome 3: Sport and Recreation;
- Australian Sports Anti-Doping Authority (ASADA); and
- Australian Sports Commission (ASC).

Whole of Portfolio/Corporate Matters

2.3 Proceedings commenced with questions on the distribution of continuous glucose monitoring devices (CGMDs) by the Government following an election promise made in 2016.[1] Mr Andrew Stewart, Deputy Secretary, Health Benefits Group, provided information to the committee on progress made within DOH regarding CGMDs:

> 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.[2]

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1 *Proof Committee Hansard*, 1 March 2017, p. 6.

2 *Proof Committee Hansard*, 1 March 2017, p. 6.

2.4 Dr John Skerrit, Deputy Secretary, Health Products Regulation Group, provided information to the committee on access to medicinal cannabis in Australia and the processes by which medical practitioners can be authorised to prescribe medicinal cannabis. Dr Skerrit reported that there are currently 23 authorised providers of medical cannabis in Australia.[3]

2.5 In response to questions from the committee on the global overview of health expenditure DHO provided the following information, summarising a more extended response:

> 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—[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.[4]

2.6 The committee sought evidence on the costs associated with dispute resolution between the Commonwealth and Philip Morris regarding the plain packaging of tobacco products in Australia. Mr Martin Bowles PSM, Secretary, DOH, informed the committee that DOH would not provide a response at present, as DOH did not wish to risk prejudicing ongoing dispute resolution processes.[5]

2.7 Australia's new Chief Medical Officer (CMO), Professor Brendan Murphy, responded to questions regarding DHO's consideration of the potential effectiveness of taxing sugar-sweetened beverages.[6]

2.8 The committee heard evidence on voluntary redundancies in DOH and Mr Bowles provided the following context:

> 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

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3 *Proof Committee Hansard*, 1 March 2017, p. 9.

4 *Proof Committee Hansard*, 1 March 2017, p. 14.

5 *Proof Committee Hansard*, 1 March 2017, p. 17.

6 *Proof Committee Hansard*, 1 March 2017, p. 18.

> call our affordable staffing level for the 2017-18 year, and one of the mechanisms we will use is voluntary redundancies.[7]

2.9 In response to further questioning on the number of DOH's voluntary redundancies, Mr Bowles said:

> 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.[8]

2.10 The committee queried whether DOH had given consideration to the health consequences of applying the GST to fresh produce.[9]

Australian Institute of Health and Welfare

2.11 The committee questioned the Australian Institute of Health and Welfare (AIHW) on its report on veterans' suicide from late 2016. In particular, the committee sought clarification of AIHW's procedures regarding collection of data from other entities used to produce AIHW's reports and the subsequent restrictions on the use of the data.[10]

Outcome 4: Individual Health Benefits

2.12 The committee sought clarification of the operations of the Medical Benefits Schedule (MBS) Review Taskforce. DOH advised that:

- the taskforce will examine all 5700 items on the MBS and to date has examined 57 per cent of items;
- the taskforce is currently supported by 17 clinical committees—with a further 17 committees expected to be established—that are currently comprised of 450 clinicians and supported by working groups; and
- funding for the taskforce, along with the Medical Services Advisory Committee (MSAC), is approximately $34 million over two years.[11] [12]

2.13 DOH could not provide a date by which the MBS Review Taskforce was expected to complete its review, however advised they were continuing to work with the chair of the committee as to the pace with which the new committees would be established.[13]

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7 *Proof Committee Hansard*, 1 March 2017, p. 19.

8 *Proof Committee Hansard*, 1 March 2017, pp. 19–20.

9 *Proof Committee Hansard*, 1 March 2017, p. 8.

10 *Proof Committee Hansard*, 1 March 2017, p. 10.

11 *Proof Committee Hansard*, 1 March 2017, pp. 23–24.

12 *Proof Committee Hansard*, 1 March 2017, pp. 28–29.

13 *Proof Committee Hansard*, 1 March 2017, p. 23.

2.14 The committee heard evidence on DOH's consultation with the medical community regarding changes to the skin care items on the MBS and MSAC's role in recommending changes from an evidence-based, clinical perspective. DOH' officers informed the committee of changes to a range of skin services items and noted that 57 skin items have been consolidated into a new schedule, which primarily impacts on the MBS.[14]

2.15 The committee sought clarification on the treatment options for people with hearing loss should the National Disability Insurance Agency (NDIA) set a different minimal hearing loss threshold level from that currently set by DOH.[15]

2.16 Senators questioned DOH on a range of health care insurance matters, including: the operating arrangements for the payment of the health care rebate to insurers; the administrative and approvals processes by which an entity is accredited as health care insurer; and the increased costs of private health insurance premiums in Australia from 1 April 2016.[16] The issue of increased health insurance premiums was also revisited later in the hearing.[17]

2.17 Senators queried DOH on delays with its review of the Life Savings Drugs Program (LSDP). The committee heard evidence on the criteria by which drugs are funded through the LSDP and specifically inquired into the status of the drug VIMIZIM, used to treat Morquio A syndrome, which is currently waiting for evaluation to be included in the LSDP.[18] Senators further examined LSDP funding arrangements.[19]

2.18 The committee received evidence on the administrative mechanisms available to review health care insurance policies, the role of DOH and the Australian Competition and Consumer Commission (ACCC) in advising government on private health insurance policy matters, and the rates of private health insurance coverage amongst the Australian population.[20]

2.19 The committee discussed the conditions of the government's proposed changes to the Child Dental Benefits Schedule (CDBS). The committee also received evidence of the utilisation rates of the CDBS, the associated proposed expenditure for the scheme and the methods used by DOH to communicate information to the public on the CDBS.[21]

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14 *Proof Committee Hansard*, 1 March 2017, pp. 24–25.

15 *Proof Committee Hansard*, 1 March 2017, pp. 30–32.

16 *Proof Committee Hansard*, 1 March 2017, pp. 34–39.

17 *Proof Committee Hansard*, 1 March 2017, pp. 49–51.

18 *Proof Committee Hansard*, 1 March 2017, pp. 34–43.

19 *Proof Committee Hansard*, 1 March 2017, p. 44.

20 *Proof Committee Hansard*, 1 March 2017, pp. 46–48.

21 *Proof Committee Hansard*, 1 March 2017, pp. 52–59.

2.20 The committee finalised its examination of Outcome 4: Individual Health Benefits with questions on bulk billing rates.[22]

Outcome 2: Health Access and Support Services

2.21 The committee sought clarification of the location of suicide prevention trial sites in Australia and the information used in deciding where to establish trial sites. Ms Natasha Cole, First Assistant Secretary, Health Services Division, provided the following information on trial site locations within the Primary Health Networks (PHNs):

> 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.[23]

2.22 Ms Cole explained that, in providing advice regarding the location of suicide prevention trial sites, DOH had considered relevant demographic data together with the capability of the communities concerned. Ms Cole clarified that:

> 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.[24]

2.23 The committee inquired more broadly into the provision of mental health services through PHNs, particularly in relation to the mental health care reforms announced by the Government in November 2016. DOH reported that each of the 32 PHNs undertakes a needs assessment as part of the reforms process and this

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22 *Proof Committee Hansard*, 1 March 2017, pp. 61–64.

23 *Proof Committee Hansard*, 1 March 2017, p. 64.

24 *Proof Committee Hansard*, 1 March 2017, p. 68.

assessment is submitted to DOH for inclusion in health commission plans, which are used to align the requirements of PHNs with a flexible funding pool. The committee subsequently expressed concern that certain existing mental health programs were not subject to continuity of funding under the arrangements of the mental health reforms. The committee broadly discussed proposed appropriations for mental health services.

2.24 Senators queried DOH's actions to address the rising rates of obesity in Australia. Dr Wendy Southern PSM, Deputy Secretary, National Program Delivery Group, provided the committee with the following information:

> 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.[25]

2.25 The committee considered other matters including:

- whether DOH would be providing a response to recommendations arising from a recent report by CRANAplus on the remote health workforce;[26]
- DOH's administration of the *Tobacco Plain Packaging Act 2011*, including the number of noncompliance complaints received by DOH and the subsequent follow-up action taken;[27]
- the state of negotiations related to the funding of Mersey Community Hospital in north-west Tasmania, including when funding negotiations would be resolved and the funding options explored during the negotiations;[28]
- DOH's implementation plan for the National Diabetes Strategy 2016–2020;[29]
- administration of the National Cancer Screening Register and the involvement of Telstra as a significant service delivery partner;[30]

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25 *Proof Committee Hansard*, 1 March 2017, p. 97.

26 *Proof Committee Hansard*, 1 March 2017, p. 80.

27 *Proof Committee Hansard*, 1 March 2017, p. 88.

28 *Proof Committee Hansard*, 1 March 2017, p. 92.

29 *Proof Committee Hansard*, 1 March 2017, p. 99.

- the funding arrangements of Non-Government Organisation Treatment Grants Program and the Substance Misuse Service Delivery Grants Fund;[31]
- particulars of the Health Care Homes reform including the program's proposed commencement date;[32] and
- the Aboriginal and Torres Strait Islander (ATSI) community concerns in relation to the review of payments under the Practice Incentives Program and DOH's commitment to work with the ATSI community.[33]

Food Standards Australia New Zealand

2.26 The committee was presented with information on commercial milk formula for children over twelve months of age and infant formula for children less than twelve months of age. In particular, the committee heard how Food Standards Australia New Zealand (FSANZ) refers matters of milk formula compliance to the state and territory authorities responsible for enforcing the Food Standards Code.[34]

2.27 Senators also inquired into the composition of FSANZ's advisory committee for genetically modified foods.[35]

Outcome 6: Ageing and Aged Care

2.28 The committee questioned DOH on an apparent decline of the number of Aged Care Assessment Team (ACAT) assessments and a purported increase in wait times for assessments to occur. DOH clarified the characteristics of the ACAT assessment process, namely the agreements in place with states and territories for the provision of ACAT assessments, the tiered approach to the prioritising assessments and DOH's Key Performance Indicator (KPI) reporting for ACAT assessments.[36]

2.29 The committee discussed the means by which DOH may improve access to mental health care services for people in residential aged-care. DOH acknowledged that there are issues in this area and noted that they are being addressed to some extent through the MBS review process. [37] DOH took a number of related questions on notice (QoNs).

2.30 Senators also made inquiries into:

- DOH's efforts address to Alzheimer's in Australia and were particularly interested in the timing of the availability of places in the Short-Term

30 *Proof Committee Hansard*, 1 March 2017, p. 100.

31 *Proof Committee Hansard*, 1 March 2017, p. 109.

32 *Proof Committee Hansard*, 1 March 2017, p. 113.

33 *Proof Committee Hansard*, 1 March 2017, p. 120.

34 *Proof Committee Hansard*, 1 March 2017, p. 122.

35 *Proof Committee Hansard*, 1 March 2017, p. 123.

36 *Proof Committee Hansard*, 1 March 2017, pp. 124–126.

37 *Proof Committee Hansard*, 1 March 2017, pp. 126–127.

Restorative Care Program (STRCP) and the distribution of STRCP places;[38] and

- the financial circumstances of younger Australian's with permanent disabilities living in aged care facilities, namely that 85 per cent of the pension that these individuals receive is paid in fees to the aged care facility.[39]

Outcome 5: Regulation, Safety and Protection

2.31 The committee continued its questioning on medicinal cannabis in Australia. In response to a question on the application process for a doctor seeking to become an approved prescriber of medicinal cannabis, Dr Skerrit provided the committee with the following explanation:

> 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 of individual patients who have 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: 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.[40]

2.32 Dr Skerrit clarified actions taken by DOH to improve the knowledge base for medicinal cannabis among general practitioners, the process by which patients can be approved to be prescribed medicinal cannabis and the processing lag times associated with the Commonwealth and state and territory entities tasked with administering the approvals process.[41]

2.33 The committee also sought information in relation to the production of the vaccine Bexsero by GlaxoSmithKline and the associated supply issues in Australia.[42]

National Health and Medical Research Council

2.34 Professor Anne Kelso, Chief Executive Officer (CEO), National Health and Medical Research Council (NHMRC) provided information to the committee on NHMRC's consideration of proposals for targeted research into Myalgic Encephalomyelitis and Lyme-like illness in Australia. Professor Kelso outlined the challenges associated with examining these research proposals and informed the committee of NHMRC's intent to seek expert advice to consider the proposals.

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38 *Proof Committee Hansard*, 1 March 2017, p. 129.

39 *Proof Committee Hansard*, 1 March 2017, p. 132.

40 *Proof Committee Hansard*, 1 March 2017, p. 133.

41 *Proof Committee Hansard*, 1 March 2017, p. 133.

42 *Proof Committee Hansard*, 1 March 2017, pp. 137–138.

Professor Kelso assured the committee that whilst there is no specific forward timeline for review of the Myalgic Encephalomyelitis and Lyme-like illness research proposals, the proposals are still in consideration.[43]

Australian Sports Anti-Doping Authority

2.35 The committee heard evidence on ASADA's current and anticipated staffing levels, in addition to information on progress made with consideration of the review of ASADA's funding model.

2.36 The committee noted Mr McDevitt's contract as ASADA's CEO expires in early May 2017 and the committee wished Mr McDevitt all the best in his future endeavours.

Australian Sports Commission

2.37 The committee welcomed Ms Kate Palmer, CEO of the Australians Sports Commission (ASC) and congratulated her on new role as CEO. The committee:

- requested that the ASC take a number of questions on notice in relation to the details of meetings attended by the former Minister for Sports, the Hon. Susan Ley MP, specifically in relation to the 2018 Gold Coast Commonwealth Games;[44] and
- questioned funding matters pertaining to the Southern Stars cricket team, Deaf Sports and the Special Olympics.[45]

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43 *Proof Committee Hansard*, 1 March 2017, p. 139.

44 *Proof Committee Hansard*, 1 March 2017, p. 141.

45 *Proof Committee Hansard*, 1 March 2017, pp. 145–147.