COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Estimates

(Public)

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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Monday, 2 June 2014

Members in attendance: Senators Boyce, Carol Brown, Di Natale, McLucas, Moore, O'Neill, Peris, Polley, Rhiannon, Seselja, Siewert, Smith, Thorp, Whish-Wilson, Wright, Xenophon.

HEALTH PORTFOLIO

In Attendance

Senator Nash, Assistant Minister for Health

Whole of Portfolio

Professor Jane Halton, Secretary

Professor Chris Baggoley, Chief Medical Officer

Ms Kerry Flanagan, Deputy Secretary

Mr David Learmonth, Deputy Secretary

Mr Chris Reid, General Counsel

Mr Andrew Stuart, Deputy Secretary

Ms Mary McDonald, Acting Deputy Secretary

Mr Paul Madden, Chief Information and Knowledge Officer

Dr Rosemary Bryant, Chief Nurse and Midwifery Officer

Mr John Barbeler, Chief Financial Officer

Mr Colin Cronin, Assistant Secretary, Audit and Fraud Control

Mr Adam Davey, First Assistant Secretary, People, Capability and Communication Division

Ms Sue Campion, First Assistant Secretary, Grant Services Division

Ms Bettina Konti, First Assistant Secretary, Information Technology Division

Mr Simon Cotterell, Acting First Assistant Secretary, Portfolio Strategies Division

Outcome 1

Mr Nathan Smyth, First Assistant Secretary, Population Health Division

Dr Bernie Towler, Principal Medical Adviser

Associate Professor Rosemary Knight, Principal Advisor

Ms Julianne Quaine, Acting First Assistant Secretary, Office of Health Protection

Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Division

Ms Sue Campion, First Assistant Secretary, Grant Services Division

Mr Steve McCutcheon, Chief Executive Officer, Food Standards Australia New Zealand

Dr Marion Healy, Executive Manager, Risk Assessment, Food Standards Australia New Zealand

Mr Peter May, General Manager, Legal and Regulatory Affairs, Food Standards Australia New Zealand

Professor Helen Zorbas AO, Chief Executive Officer, Cancer Australia

Professor Warwick Anderson, Chief Executive Officer, National Health and Medical Research Council

Dr Timothy Dyke, Executive Director Research Policy Development Taskforce, NHMRC

Professor John McCallum, Head, Research Translation Group, NHMRC

Mr Tony Kingdon, General Manager and Head, Planning and Operations Group and Research Group, NHMRC

Ms Louise Sylvan, Chief Executive Officer, Australian National Preventative Health Agency

Ms Jan Bennett, Advisor, Australian National Preventative Health Agency

Dr Judith Winternitz, Manager Policy and Programs, Australian National Preventative Health Agency

Mr David Kalisch, Director, Australian Institute of Health and Welfare

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

Dr Pamela Kinnear, Head Australian Institute of Health and Welfare

Ms Lisa McGlynn, Head, Health Australian Institute of Health and Welfare

Prof Debora Picone AM, Chief Executive Officer, Australian Commission on Safety and Quality in Health Care

Mr Mike Wallace, Chief Operating Officer, Australian Commission on Safety and Quality in Health Care

Outcome 2

Ms Felicity McNeill, First Assistant Secretary, Pharmaceutical Benefits Division

Outcome 3

Dr Richard Bartlett, First Assistant Secretary, Medical Benefits Division

Mr Nathan Smyth, First Assistant Secretary, Population Health Division

Dr Bernie Towler, Principal Medical Adviser

Associate Professor Rosemary Knight, Principal Advisor

Ms Janet Anderson, First Assistant Secretary, Acute Care Division

Mr Charles Maskell-Knight, Principal Adviser

Dr Andrew Singer, Principal Medical Adviser

Outcome 4

Ms Janet Anderson, First Assistant Secretary, Acute Care Division

Mr Charles Maskell-Knight, Principal Adviser

Dr Andrew Singer, Principal Medical Adviser

Mr Leigh McJames, General Manager and Chief Executive Officer, National Blood Authority

Ms Yael Cass, Chief Executive Officer, Australian Organ and Tissue Donation and Transplantation Authority

Ms Judy Harrison, Chief Financial Officer, Australian Organ and Tissue Donation and Transplantation Authority

Dr Tony Sherbon, Chief Executive Officer, Independent Hospital Pricing Authority

Outcome 5

Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Division

Ms Samantha Palmer, First Assistant Secretary, Indigenous and Rural Health Division

Mr David Butt, Chief Executive Officer, National Mental Health Commission

Outcome 6

Dr Richard Bartlett, First Assistant Secretary, Medical Benefits Division

Mr Shaun Gath, Chief Executive Officer, Private Health Insurance Administrative Council

Mr Paul Groenewegen, General Manager and Deputy Chief Executive Officer, Private Health Insurance Administrative Council

Mr Neil Smith, General Counsel

Ms Samantha Gavel, Private Health Insurance Ombudsman

Outcome 7

Ms Linda Powell, First Assistant Secretary, eHealth Division

Ms Fay Holden, Acting First Assistant Secretary, Best Practice Regulation and Deregulation Division

Ms Julianne Quaine, Acting First Assistant Secretary, Office of Health Protection

Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Division

Mr Nathan Smyth, First Assistant Secretary, Population Health Division

Dr Bernie Towler, Principal Medical Adviser

Associate Professor Rosemary Knight, Principal Advisor

Ms Janet Anderson, First Assistant Secretary, Acute Care Division

Mr Charles Maskell-Knight, Principal Adviser

Dr Andrew Singer, Principal Medical Adviser

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

Dr Michael Dornbusch, Acting Regulator, Office of Gene Technology Regulator

Professor John Skerritt, National Manager, Therapeutic Goods Administration

Dr Anthony Hobbs, Principal Medical Adviser

Ms Elizabeth Flynn, Chief Operating Officer

Dr Larry Kelly, Head, Monitoring and Compliance Group

Dr Lisa Studdert, Head, Market Authorisation Group

Ms Philippa Horner, Principal Legal Adviser

Ms Nicole McLay, Chief Financial Officer

Mr Steve McCutcheon, Chief Executive Officer, Food Standards Australia New Zealand

Ms Phillipa Smith, Food Standards Australia New Zealand

Dr Paul Brent, Chief Scientist, Food Standards Australia New Zealand

Ms Melanie Fisher, Deputy Chief Executive Officer, Food Standards Australia New Zealand

Dr Marion Healy, Food Standards Australia New Zealand

Outcome 8

Ms Penny Shakespeare, First Assistant Secretary, Health Workforce Division

Mr Ian Crettenden, Acting Chief Executive Officer, Health Workforce Australia

Mr Roberto Bria, Executive Director, Corporate and Finance

Mr Ben Wallace, Executive Director, Clinical Training Reform

Ms Megan Cahill, Chief Executive Officer, General Practice Education and Training

Mr Ian Crettenden, Acting Chief Executive Office, Health Workforce Australia

Outcome 9

Ms Julianne Quaine, Acting First Assistant Secretary, Office of Health Protection

Outcome 10

Mr Jaye Smith, Acting First Assistant Secretary, Office for Sport

Mr Andrew Godkin, First Assistant Secretary, National Integrity of Sport Unit

Mr Simon Hollingsworth, Chief Executive Officer, Australian Sports Commission

Mr Matt Favier, Director, Australian Institute of Sport

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

Elen Perdikogiannis, General Manager, Australian Sports Anti-Doping Authority

Mr Steve Fitzgerald, Chief Financial Officer, Australian Sports Anti-Doping Authority

Ms Sue Campion, First Assistant Secretary, Grant Services Division

Committee met at 09:08

CHAIR (Senator Boyce): I declare open this hearing of the Community Affairs Legislation Committee, and I apologise to everyone for the late start—the committee just had a quick private meeting. The Senate has referred to the committee the particulars of proposed expenditure for 2014-15 and related documents for the portfolios of Health and Social Services, including human services. The committee may also examine the annual reports of the departments and agencies appearing before it. The committee is due to report to the Senate on Tuesday, 24 June and has fixed Friday, 25 July as the date for the return of answers to questions taken on notice. Senators are reminded that any written questions on notice should be provided to the committee secretariat by close of business Thursday, 12 June. The committee's proceedings today will begin with its examination of the Health portfolio, commencing with whole-of-portfolio and corporate matters. Under standing order 26, 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 the departments and agencies which are seeking funds in the estimates are relevant questions for the purpose of estimates hearings. I remind officers that the Senate has resolved that there are no areas in connection with the expenditure of public funds where any person has the discretion to withhold details or explanations from the parliament or its committees, unless the parliament has expressly provided otherwise.

The Senate has resolved that an officer of a department of the Commonwealth shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude questions asking for explanations of policies or factual questions about when and how policies were adopted. I particularly draw the attention of witnesses to an order of the Senate of 13 May 2009 specifying the process by which a claim of public interest immunity should be raised.

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 (I) 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).

(Extract, Senate Standing Orders, pp 124-125)

Witnesses are specifically reminded that a statement that information or a document is confidential or consists of advice to government is not a statement that meets the requirements of the 2009 order. Instead, witnesses are required to provide some specific indication of the harm to the public interest that could result from the disclosure of the information or the document.

[09:12]

CHAIR: I welcome Senator the Hon. Fiona Nash, representing the Minister for Health, and officers of the Department of Health. We will welcome Professor Halton anytime soon, I am sure.

Ms Flanagan: Yes, Professor Halton is on her way.

CHAIR: Minister, do you have an opening statement?

Senator Nash: No, I do not.

CHAIR: Let us proceed to questions in the whole-of-portfolio area.

Senator McLUCAS: I expressed my disappointment in the private meeting about the way this meeting is being chaired and I put it on record now. I think we should chair it as we have done in the past, rather than block time out.

CHAIR: I am very conscious of wanting to keep the committee to time.

Senator McLUCAS: We have always been able to keep to time without working like this.

CHAIR: Perhaps you could start asking questions.

Senator McLUCAS: When was the department asked to begin policy work or policy development around the Medical Research Future Fund?

Ms Flanagan: I will need to take that on notice, just to make sure we can give you the right day.

Senator McLUCAS: Could you just give me an indication? I acknowledge you will not have the date in your head, but when generally?

Ms Flanagan: Probably sometime in April, but, as I say, I would need to check when that was.

Senator McLUCAS: Will we be able to get that date later today?

Ms Flanagan: I will check whether we can do that.

Senator McLUCAS: Did the policy development work all occur in Health?

Ms Flanagan: No, it was shared across government, as many of these budget processes are, as you would appreciate.

Senator McLUCAS: Which departments were involved?

Ms Flanagan: All of the departments represented on the Expenditure Review Committee plus the line department. You would appreciate that there might have been other involvement, but I cannot tell you what that might have been.

Senator McLUCAS: Did department provide advice around the structure of the fund?

Ms Flanagan: No, we did not. As you would appreciate, it is set up and will be administered by the Department of Finance and administered by the Future Fund Board.

Senator McLUCAS: In terms of the way the fund will operate, what is health's understanding of the way that the fund will operate?

Ms Flanagan: I would say that these are probably more details that should go to the Department of Finance, as they will be administering the fund. My understanding is that it has started with leftover funds in the Health and Hospitals Fund. That is, funding in that fund that is not to be used will actually transfer into the Medical Research Future Fund.

Senator McLUCAS: Can you please tell me about the figure?

Ms Flanagan: I think it is around $900 million. Ms Anderson might be able to give you the figure. It is basically the interest, plus a small amount of funding that was not utilised or passed back into the Health and Hospitals Fund.

Ms Anderson: That is correct. It is around $900 million in that HHF fund, which will be closed down with no further allocations to be made from that fund.

Senator McLUCAS: Sorry, can you say that again?

Ms Anderson: It is about $900 million. The fund, as you know, has been fully expended through four rounds. There is an amount which is remaining in the fund from the $5 billion. It is largely from interest accrued on the unspent portion, which is now going to be moved across as one of the first investments in the Medical Research Future Fund.

Senator McLUCAS: That is the money that would have gone directly to hospitals in which year?

Ms Flanagan: The large majority of this interest, which was being earned on the fund, was not part of the original capital amount that could have been drawn down to fund projects. So government would have had to take a decision about how to utilise the interest in the fund.

Senator McLUCAS: With the way it was established as a fund, it was always going to be on interest. So the original intention was that that money would go to health and hospital expenditure, I expect.

Ms Flanagan: I would need to check the original intention of the fund and how that interest was to possibly be used. But, certainly, this is a slightly different fund to the Medical Research Future Fund, in that the capital was actually drawn down and specifically to be used for health and hospital infrastructure.

Senator McLUCAS: It was specifically to be used for health and hospital activity.

Ms Flanagan: Yes, but I am not clear on the interest in the fund, as to how that was specified to be used.

Ms Anderson: Just to follow up on that, $4.94 billion from the Health and Hospitals Fund has been committed for infrastructure projects. That is very close to the $5 billion.

Senator McLUCAS: But there is no $100 million as interest. Where does that appear in the budget, as to the health portfolio?

Ms Flanagan: It does not appear in the health portfolio, because it is a fund administered through the Minister for Finance.

Senator McLUCAS: On the $276.2 million over three years, that is all from the GP tax? Is that right?

Ms Anderson: It is a combination. The way the fund is proposed to work is that it will progressively accumulate its capital base and will achieve the $20 billion target by about 2020. The draw downs from the fund and the payments from the fund will commence, as the budget papers indicate, from 2015-16. The first payment is $19.9 million in that year. It builds progressively over time. Across the forward estimates, it will be the $276.2 million that you identified. The capital will be formed by the remaining balance of the Health and Hospitals Fund and the health savings accumulating from 2014-15 onwards.

Senator McLUCAS: When you say health savings, is that the GP super tax? Sorry, GP tax. Maybe it is a super tax!

Senator Nash: I would characterise it as a co-payment.

Senator McLUCAS: The savings in the budget show $19.9 million, $77 million and $179.3 million. Can you explain what those figures are?

Ms Anderson: They are payment from the fund. The fund accumulates as an endowment fund where the capital is preserved.

Senator McLUCAS: Payment from the fund?

Ms Anderson: From the fund. They are not the deposits in; they are the interest earned—the net earnings from the fund, which can be disbursed.

Senator McLUCAS: What I am now seeking, though, is the payments from Health into the fund. Where do I find those?

Ms Flanagan: The government has committed to put savings that have been published from the Department of Health into the fund. Again, we would need to take that on notice because that calculation, I think, was done by Treasury. We can actually see whether we can get you that information as to how it accumulates into the fund.

Senator McLUCAS: At various points in the PBS, but more in budget paper No. 2, it shows that all savings from Health will go into the fund. What I want is a list of the components of those elements that are going into the fund. So, the $166 million from Aboriginal health will go into the fund. How much from the tax on going to the doctor will go into the fund? We need to understand those contributions that are coming from Health into the fund fully, and I am sure you have done those figures in Health as well as in Finance and Treasury.

Ms Flanagan: We can give you the published saving that have come out of the Department of Health over the forward estimates period; however, the fund does not reach full maturity until after the forward estimates period. So, that is where calculations have been done that we will not necessarily be able to give you a lot of information on, which is why we would need to go to Treasury on that. But we can certainly do it for the forward estimates period.

Senator McLUCAS: But what we want to know is how much is coming out of the different sections of the Department of Health to the fund, and particularly the elements that are due to the changed operation of paying to go to the doctor.

Senator Nash: If I can assist also, the Indigenous health savings, as I understand it, are around $121 million.

Senator McLUCAS: That is only if you add the $44 million that is ostensibly an increase in funding from the final year. My understanding, from Friday, is that the figure, at least, is $160-something—$164 million or $166 million.

Ms Flanagan: Basically, all of the measures—we can do this reconciliation—that have been reflected in the budget papers should add, in effect, to the yearly inputs to the fund.

Senator McLUCAS: Yes, but I want them disaggregated so that we know where they are coming from. Will the earnings from the fund be used to fund proposals put to the NHMRC or to the fund itself?

Ms Flanagan: As I said, we do not have that amount of detail yet. My understanding is that the intention for the earnings from the fund, as they are drawn down each budget, is for the priorities for the fund to be set in the budget. However, I would imagine that the government will be drawing up, as it did for the Health and Hospitals Fund, in effect, terms of reference for what the fund, when they legislate for it, would be able to be used for.

Senator McLUCAS: So, this will not be on a competitive basis at all?

Ms Flanagan: The intention is that much of the funding would come through the NHMRC, but again I do not have the level of detail yet to let you know how that is actually going to be implemented.

Senator McLUCAS: And who is doing the design work of the operation of the fund when it is going to be actually used for research.

Ms Flanagan: Initially the work that is being done on the fund is about setting it up, and the Department of Finance is doing that in terms of what its investment strategy will be and things like that. We will be doing work—we are only at the very preliminary stages of doing this—on, when the fund is being drawn down, from 2015-16 on, how the fund earnings will be distributed.

Senator McLUCAS: But we know the way the NHMRC works.

Ms Flanagan: We do.

Senator McLUCAS: It is all a competitive process of being provided with research money. You are saying to me, I think, that this is going to operate with the government setting those priorities rather than having the competitive nature of research grants that NHMRC operates.

Ms Flanagan: And I think the NHMRC already has priorities where money is invested.

Senator McLUCAS: It is very broad, though.

Ms Flanagan: Yes. I imagine that it would operate in the same way.

Senator McLUCAS: Will the money supplement NHMRC funding?

Ms Flanagan: That is certainly the government's stated intention.

Senator McLUCAS: Is there any mechanism to quarantine the NHMRC funding? Or will it operate in a single line item now?

Ms Flanagan: I am not quite sure what you mean by that.

Senator McLUCAS: Will all the NHMRC money—with its own structures around how it is disbursed—and the Future Fund money come into one process of delivery, or will it be two different streams?

Ms Flanagan: We do not yet have that level of detail around the design.

Senator McLUCAS: Was consideration given to the fact—I think 'fact' is probably the right word—that medical outcomes often rely on research and development in sciences outside what is conventionally considered as the health sciences? You may have seen Sir Gus Nossal's comments on this. Health research is not purely in the health area. There is science outside of those health areas that need to be included. Has consideration for the need for a broader approach been part of the thinking at the moment?

Ms Flanagan: Again, I think the government has stated what it intends for the Medical Research Future Fund to do—the drawdowns from that fund. We can give you the wording for that. That is what the government has decided.

Senator McLUCAS: Will the fund pay for clinical trials?

Ms Flanagan: Again, it is a design feature that I think we need to look at.

Prof. Halton: The government has indicated that clinical trials may well be part of this.

Senator McLUCAS: What discussions have you had with the medical research community, both prior to the budget and post the budget?

Ms Flanagan: I think there have been a range of conversations by the government around medical research. I believe that the Prime Minister and the minister were at the Victor Chang Cardiac Research Institute on Saturday, and I know that they have been having discussions with the medical research community.

Senator McLUCAS: Is it an ad hoc approach, or is there a plan to have a formal consultation with the medical research community?

Ms Flanagan: As I said, we can check that. But, certainly, I know that there are a lot of conversations going on with the medical research community at the moment.

Senator MOORE: In terms of this whole process, what we are trying to find out about—now that it is a public announcement; it is not private in any sense now—is the range of medical research, which we always question in this portfolio in terms of NHMRC, Cancer Australia and those areas. This was the area where we talked about allocation through Health to medical research as well as through the departments of science and so on. But medical items were here. We are trying to find out exactly how that all links together and what the role of Health is going to be in what is operating in this brand new fund. Do you have any indication yet about how that is going to operate?

Prof. Halton: We need to go back to what the government said in the budget context. The money would be allocated to the Future Fund guardians for investment and then the government would take a decision on an annual basis about the distribution of funds. The government has said that it is their expectation they will allocate on an annual basis. They may well indicate priorities. They talked about the notion of clinical trials and with the NHMRC, the expected vehicle for disbursement, but that does not mean it is guaranteed that 100 per cent will be via that route. A number of these details have yet to be determined. Beyond that, we cannot provide a great deal of clarity, other than to say that the existing mechanisms—our expectation is—will largely be used. It is not the expectation that the Future Fund guardians will have anything to—

CHAIR: Fairfax media, you cannot take photographs of the committee without seeking permission to do so. Are you seeking permission?

Unidentified speaker: Yes, I am seeking permission.

CHAIR: Is the committee happy with that? Yes? Thank you.

Senator MOORE: What are the normal processes, Dr Halton, just to clarify the record. You said that you expect the standard processes would apply.

Prof. Halton: In other words, whilst money is guarded by the guardian—sorry, too many guardians in there.

Senator MOORE: It is an unfortunate term—

Prof. Halton: It is not our expectation that the money will be in any way disbursed by them; it will be held by them for investment purposes. In terms of the distribution of those funds and as is now the case, as you know, with governments deciding and in some cases there are priorities at a particular time, largely our existing mechanisms will be used, but there is still some discussion to be had on that. Our existing mechanisms, as you know, are the NHMRC, and you also mentioned Cancer Australia.

Senator MOORE: Yes.

Prof. Halton: So we have a couple of existing mechanisms. Will there be more? Don't know. But is it our expectation that those funds will be managed inside the portfolio, subject to government decision about priorities? Yes, it is.

Senator MOORE: Within your portfolio.

Prof. Halton: That is our expectation. At the end of the day, not all those details are sorted out yet, but that is our expectation.

Senator MOORE: And also the consultative or discussion process with the existing established medical resource bodies, can we ask whether there is going to be a strategic approach for that as well, whether there is a business plan for that work?

Prof. Halton: Again, this is a subject for further discussion. Would it be my expectation that the normal process of dialogue, robust and regular, with the research sector will occur? Yep; it is. Is there something I can point you to yet? No. But as Ms Flanagan has indicated, there has already been a series of discussions—led by the Prime Minister, not just by our minister—in relation to their interest and priority to research in this domain.

Senator MOORE: Have those discussions, in terms of this process, always included your minister as well as the Prime Minister?

Prof. Halton: Yes.

Senator MOORE: Who is driving it, in terms of those discussions with the process?

Prof. Halton: I am not privy to prime ministers' diaries. I do not know who he has been having discussions with; he is entitled to talk to anyone he wishes. But in terms of: is our minister taking an absolutely key interest? Yes he is.

Senator MOORE: Minister, can we clarify whether the discussions with the industry around this issue include the health minister? Is that the standard process, the health minister being involved in those processes?

Senator Nash: That is my understanding. If that is not correct, I will come back to you.

Senator DI NATALE: Dr Halton, tell me whether these questions are best directed here or elsewhere. Questions around the changes to the Private Health Insurance Act, particularly with a view to deregulation and the involvement of private health insurance in primary care, is that something best deferred to the section on private health?

Prof. Halton: Yes, the officers who can answer those questions will be here under the private health section; that is correct.

Senator DI NATALE: Thank you.

Senator McLUCAS: Ms Anderson, earlier you said that $900 million from the interest accrued on the Health and Hospitals Fund will be allocated to the Medical Research Future Fund. Were there either any contracts that were signed and are not going to be delivered on or any proposed works, out of that $900 million, that will now not be contracted to the sorts of activities that would have happened under the Health and Hospitals Fund?

Ms Anderson: The government has made it clear that no contracts committed—signed—have been affected by that movement of funds. That is literally the residual. It is not connected to any existing negotiation or contract in process.

Senator McLUCAS: Were there proposals that were not finalised or not contracted that were in the process of being contracted prior to the decision made to scoop that $900 million out of the Health and Hospitals Fund?

Ms Anderson: No.

Senator McLUCAS: Will public health or preventative health be part of the Medical Research Future Fund grants?

Prof. Halton: To the extent that they are health research, anything that qualifies as health research—yes.

Senator McLUCAS: There is a lot of money out of preventative health that has gone into this fund. A lot of money has gone out of public health activities usually operated by the Department of Health and into this fund as well.

Prof. Halton: I think we have already canvassed that health research is what is going to be covered by this fund. It depends on what the proposal is. If it qualifies under the health research banner, then we have already clarified that in relation to things like trials. I probably cannot add to that answer.

Senator DI NATALE: On that specific issue, my understanding was that the research funds would be directed to biomedical research. For example, would an evaluation of an existing health policy potentially qualify under the fund?

Prof. Halton: I think we are getting into hypotheticals here. You are quite right in terms of the description of the fund. Other than that, to answer a hypothetical question is quite difficult.

Senator DI NATALE: But you said it was health research—

Prof. Halton: Yes, health research.

Senator DI NATALE: That is a very broad term. It encompasses research, for example, on preventative measures.

Prof. Halton: Yes. So it is not my expectation that it will include systems design issues, but those issues still have to be narrowed down in terms of the description of the fund in terms of the legislation.

Senator DI NATALE: So what about preventative health interventions?

Prof. Halton: Interventions?

Senator DI NATALE: Yes—for example, research into a sun-smart program, research into a program that is directed at smoking prevention et cetera, as opposed to biomedical research.

Prof. Halton: I do not know that we have actually got enough detail to answer that question specifically. I think it is unlikely, based on the description I have seen. But, again, we are in an area that we probably cannot yet answer.

Senator DI NATALE: When you say it is unlikely, on what basis are you making that judgment?

Prof. Halton: The description of the health research as you have outlined it.

Senator DI NATALE: Can you elaborate on the description for me, as you understand it?

Prof. Halton: We have already just canvassed it. It is health research; it is not—

Senator DI NATALE: 'Health research' is a very broad term and that is why I want to nail it down.

Prof. Halton: The language that was used in the budget papers—if someone can find it, it is probably worth just reiterating that, because that is the description that we have as well. Until we get into drafting the relevant pieces of legislation to get this clarified, I do not think we can, because we are speculating.

Senator Moore interjecting—

Senator DI NATALE: Yes, that would be one issue. But with other, narrower preventative health interventions, one would—

Prof. Halton: I cannot answer that question.

Senator DI NATALE: Yes, but you indicated that you thought it was 'unlikely'. I am just wondering on what basis you think it is unlikely.

Prof. Halton: Probably, I should not have answered in that way because now we are going to go down a line which I cannot answer. So let us expunge that answer. The description in the budget papers for the Medical Research Future Fund is as it stands, and we will work through those details in the next little while. And you will be able the see the legislation in due course.

Senator DI NATALE: But, as you said, it was unlikely. I am just interested in exploring on what basis you think that preventative health interventions would be an unlikely avenue for the research fund to consider.

Prof. Halton: I was referring to the particular example you gave not the broader—

Senator DI NATALE: Okay, so why would that particular example be unlikely?

Prof. Halton: As I said, I probably should not have answered the question. Let's ignore that answer—

Senator DI NATALE: I do not want to ignore it because it obviously came from somewhere. I am interested in exploring why you gave that answer.

Prof. Halton: Because of the description in the budget measures.

Senator DI NATALE: Okay, so can you just, perhaps, explain the description and how you think it is inconsistent with a preventative health research project.

Prof. Halton: That was not the example that you gave.

Senator DI NATALE: Well, I said a SunSmart intervention.

Prof. Halton: You did. So are we talking about—

Senator DI NATALE: That is a preventative health intervention. So, perhaps, if we look specifically at that, why do you think that would be unlikely to be funded under the research fund?

Prof. Halton: As I said, I think we are now into the hypothetical. We need to be clear that we have to work through this level of detail. The medical research fund, as described, is not everything in the Health domain, by definition.

Senator DI NATALE: I am sorry, I feel like you are contradicting yourself, because a little while ago you said it is a health research fund and used that term very broadly—

Prof. Halton: It is managed by us—the Department of Health—in terms of the disbursement of the funds. We will disperse it via the NHMRC, possibly Cancer Australia and possibly some other mechanism, as yet undetermined. It is in the Health domain. It is not going to the ARC, for example. It is described in the budget papers in the way that I have just outlined. The government has indicated that they are interested in clinical trials.

Senator DI NATALE: So what you are suggesting is that this is largely about funding research where we can establish a clinical trial to get an outcome?

Prof. Halton: I am not suggesting that. I am saying that the government has consciously indicated it is prepared to consider clinical trials as part of the funding.

Senator DI NATALE: And the fact that something like a SunSmart intervention would be unlikely to be funded is because you think the focus is on clinical trials?

Prof. Halton: I do not think the focus is on clinical trials. I think it is included as a potential but it is not the emphasis.

Senator DI NATALE: Why would you assume that something like SunSmart is unlikely?

Prof. Halton: To the extent that it is about a communication as opposed to medical research. That is probably the emphasis which I took from your question.

Senator DI NATALE: That is exactly what I am trying to establish. There is biomedical research looking at things like health technology—

Prof. Halton: Clearly in scope, yes.

Senator DI NATALE: Yes. And then there are other interventions.

Prof. Halton: And then we get into the grey areas, and my point to you is the government has not clarified where the line will be drawn in the grey areas.

Senator DI NATALE: Sure. I understand that. It is good to get a sense, though, about where this is heading. I just want a sense of it at the moment. And you have already indicated to me that you think that is unlikely because you think the focus is going to be more on those clinical biomedical interventions. Is that right?

Prof. Halton: The emphasis that has been—I am about to use the same word again—underscored by the government in its descriptions of this initiative is in respect of medical research and to be administered out of the Health portfolio in the ways that I have talked about. As I have said, they have ruled in clinical trials. But, as you understand probably better than anybody else, from black through to white and the grey in between, it is very hard to draw a hard line. So I do not think there is any point us trying to split a hair here in an environment where the government has not decided—because it has not.

Senator DI NATALE: You are right, there is a spectrum. But there is also either end of the spectrum, and I am trying to tease out what is at each end of the spectrum. It sounds as if, from the evidence you are putting forward, that the focus is on the biomedical end as opposed to—

Prof. Halton: On the descriptions that have been used, that is my expectation.

Senator DI NATALE: And I think you said a bit earlier you do not think systems of research will be included.

Prof. Halton: Based on, again, the comments that have been made by the government, including by the Treasurer, I do not see that as being an emphasis. But we have to work through those details.

Senator DI NATALE: I am sorry, Senator McLucas. I have taken up too much of your time.

Senator McLUCAS: No, no. They are exactly the questions that I am trying to ask, as well.

CHAIR: I was presuming that Senator McLucas was very comfortable with that.

Senator McLUCAS: Do you expect, Ms Halton, that translational research will be included in the scope of the fund?

Prof. Halton: That detail is not yet determined.

Senator McLUCAS: Senator Di Natale did ask about health system research and you seemed to indicate that it was probably not—

Prof. Halton: Based on the descriptions that have been used in the budget documentation and since by the government; but, as I have said, that level of detail is actually not yet determined and that will be determined in the framing of the legislation.

Senator McLUCAS: How about applied research and evaluation relating to implementation?

Prof. Halton: I think again we are in the same domain, Senator.

Senator McLUCAS: And prevention and the social determinates of health?

Prof. Halton: Ditto.

Senator McLUCAS: There is particular concern from the mental health sector about how the mental health community would access these types of funds, given that the methodology around mental health research is often very different from the straight medical research. How would you answer questions from that sector about how they would be included in accessing these funds?

Prof. Halton: I would say that we cannot yet answer those questions.

Senator McLUCAS: Given that quite a significant amount of money has come out of mental health to go into this fund, you can understand the concern that the sector is expressing.

Prof. Halton: You are asking me for an opinion, Senator, which I am not going to give you.

Senator McLUCAS: Fair enough.

Senator MOORE: Professor Baggoley, have you been involved in the discussions to date about this particular medical research fund? Has your role, position, actually got a particular focus at this early stage?

Prof. Baggoley: No.

Senator MOORE: Ms Halton, you were talking about the standard ways that this kind of work is done in terms of interaction about research and so on. Is the Chief Medical Officer's role engaged currently in the different ways that research decisions are made?

Prof. Halton: The Chief Medical Officer sits on the NHMRC, Senator.

Senator MOORE: And that is the only one of the current processes that you are involved in, Professor Baggoley?

Prof. Baggoley: Yes.

Prof. Halton: But if the government decides from time to time that there are particular priorities—indeed, this was the case under the last government and the government before that and before that, as you would remember—in, for example, dementia, mental health or whatever, the Chief Medical Officer traditionally has been part of discussion about the merits of those priorities.

Senator MOORE: That is my understanding; by reason of being the Chief Medical Officer.

Prof. Halton: Correct.

Senator MOORE: I would have thought so.

Prof. Halton: As opposed to being on the council of the NHMRC.

Senator MOORE: At this stage, none of it is clear about how that is going to operate in the future?

Prof. Halton: No. Again, the decision to create this investment structure and the description that you have had is why I think it gets very difficult when we get into anything which is other than 'black and white', because there is a process to be gone through inside government in the framing of the legislation, which will actually answer some of those questions.

Senator MOORE: I just do not think there is much that is black or white.

Senator CAROL BROWN: Following on from the questions that Senator McLucas was asking earlier in trying to ascertain exactly where the savings under the health portfolio were coming from—and we were not able to get that information—what is the quantum of savings over the forward estimates from the health department that is going into the Medical Research Future Fund?

Prof. Halton: All the published savings?

Ms Flanagan: We have agreed that we can get those to you. What we need to do is to add up the various measures that have been published to do that. But, as I said earlier, because the fund does not mature until 2022-23, anything outside the forward estimates is difficult to derive from the health portfolio.

Senator CAROL BROWN: The question was over the forward estimates.

Ms Flanagan: Yes, and I have agreed that we can do that.

Prof. Halton: We can provide you with that.

Senator CAROL BROWN: I would have thought that would have been something that you could readily give to the committee.

Prof. Halton: The trouble is that we have got to disentangle it from parameter variations. Our problem is that the aggregates are combinations of parameter variations, together with savings measures. So it has to be disentangled.

Senator CAROL BROWN: Okay.

Senator McLUCAS: Ms Flanagan, will the document that you provide essentially be the cash? Will we be able to identify the parameter variations that Ms Halton has indicated as well?

Ms Flanagan: What I was intending to do, is to give you a list of the various savings measures that have been taken in the budget in the Health portfolio and list those out for you. It will show year on year what the saving is estimated to be across the various savings measures, and that should then add to a total of what is going into the medical research fund.

Senator CAROL BROWN: Directly out of the health budget.

Ms Flanagan: Out of the health budget, yes.

Senator McLUCAS: Can you describe for us the process of putting the legislation in place to establish this fund? Will that take place in the Department of Health?

Prof. Halton: Yes.

Ms Flanagan: To develop the fund it will be financed—

Senator McLUCAS: Sorry, that should not be to establish the fund but to establish the disbursal of funds from the fund. Will Health lead that?

Prof. Halton: That is our understanding.

Senator McLUCAS: Where is that up to?

Prof. Halton: It has not yet begun because there is no legislation.

Senator McLUCAS: But health will lead that process?

Prof. Halton: In consultation. The government will be given options, and they will take decisions in relation to those options. It is not our expectation that the Treasury will be designing that process. Does that make sense?

Senator McLUCAS: I think so.

Prof. Halton: We may be talking at cross-purposes.

Senator McLUCAS: I think we may be. Will Health lead the development of the legislation that will describe how the moneys will be disbursed?

Prof. Halton: It is a bit like with HHF—Ms Flanagan, correct me if I am wrong. The Treasury and we worked—

Ms Flanagan: It was the Department of Finance, because it owns the funds. I would imagine that the legislation will refer to the investment strategy and things like that. We would not need legislation on disbursal. We would hope—

Prof. Halton: We would use the mechanisms.

Ms Flanagan: We would use normal mechanisms, and I do not think we would need legislation to do that.

Prof. Halton: That is why we refer to processes. When I referred to Treasury, I meant Department of Finance. As they did with HHF, they run that side of it. But that is the investment side, whereas the disbursal side is a government decision and mechanism as decided by government. In our expectation, that will be largely existing mechanisms but not constrained to those.

Senator McLUCAS: I want to go to the rationale for the GP co-payment now. It has been described as a sustainability measure for Medicare. I need to get an understanding of how that works. How do you—

Prof. Halton: We are not in that particular program yet, senator.

Senator McLUCAS: Do you want to leave that till we get to Medicare?

Prof. Halton: Yes, I do because the officers that are relevant need to be here for that discussion.

Senator CAROL BROWN: We may be able to answer questions about modelling as well.

Prof. Halton: About the estimation process?

Senator CAROL BROWN: Yes.

Senator McLUCAS: How much of the seven-dollar GP tax goes into the fund?

Prof. Halton: It is not a tax mechanism. There is a very particular definition of tax. It is not a tax. The co-payment, as you would know, is not all represented as a save to the budget. So they can describe to you those mechanisms.

Senator McLUCAS: That will be when we get into that. I will now move to staffing. How many full-time equivalents does the department currently have?

Mr Stuart: The current full-time equivalent in the department is 3,199.

Senator McLUCAS: How does that compare to September 2013?

Mr Stuart: Senator, that is the core department. That is the department not including the regulators.

Senator McLUCAS: Excluding the regulators.

Mr Stuart: Compared to September?

Senator McLUCAS: Compared to September, last year.

Mr Stuart: Senator, I do not have that particular piece of data in front of me.

Senator McLUCAS: What have you got?

Mr Stuart: Not since September. What I can tell you is that the department staffing has fallen by 374 people this financial year to date.

Senator McLUCAS: Okay. Was that 300?

Mr Stuart: It is 374 people this financial year to date.

Senator McLUCAS: And this is MOG exclusive.

Mr Stuart: This is after taking out the effect of the machinery of government changes.

Senator Moore interjecting—

Mr Stuart: It is holding all that aside.

Prof. Halton: Constant those ons and offs.

Mr Stuart: And, again, Senator that refers to the core department.

Senator McLUCAS: How many staff does the department employ in Canberra?

Mr Stuart: Most of our staff are now in Canberra. Adam might be able to find the numbers, but since the machinery of government changes the aged-care dominated the state offices and we now have only a couple of hundred people in the state offices. Sue might be able to tell me.

Senator MOORE: Mr Stuart, can we get these figures based on ongoing and non-ongoing categories?

Prof. Halton: That would be very difficult.

Senator MOORE: But, Professor Halton, in terms of the process they are either ongoing—'permanent staff' in the old terminology—or non-ongoing. I would have thought that that would be something that would be easy to hand.

Prof. Halton: Not given all of the machinery of government stuff. That is our problem. Our problem is that we have had so many ons and offs in terms of machinery of government. Stripping back, we have a continuous series in terms of the aggregates, but to disentangle now, retrospectively, who was ongoing and who was non-ongoing, particularly the stuff that has gone out—

Senator MOORE: I am happy for the figures as of now. We need the flat figures for the comparison, but for the current I would like—

Prof. Halton: Yes. That is fine. That we can do, but retrospectively—

Mr Stuart: I can tell you two things. One is that we have currently 153 full-time-equivalent staff in regional offices and the other is that we are currently at our lowest point historically in relation to the number of non-ongoing staff in the department. But precisely how many we had at different dates I think would be difficult to do.

Senator McLUCAS: Just in terms of that 3,199, could you split those into non-ongoing and ongoing.

Mr Stuart: We can do that on notice.

Senator McLUCAS: Thank you.

Senator MOORE: And can we get the non-Canberra based officers, by location?

Mr Stuart: Yes we can do that.

Senator MOORE: I am not asking you what buildings in Canberra, Mr Stuart—just outside Canberra.

Mr Stuart: Thank you!

Senator McLUCAS: Is the Business Service Centre still in operation?

Mr Stuart: Yes it is.

Senator McLUCAS: And how many staff are allocated to the Business Service Centre?

Mr Davey: The number of staff in the Business Services Centre at 30 April was 23.

Senator McLUCAS: And what do we expect to happen to those staff?

Mr Davey: They are still our first priority in terms of redeployment for other funded roles within the department. We will continue to use that mechanism to redeploy staff.

Senator McLUCAS: How many staff have accepted voluntary redundancies since September 2013?

Mr Stuart: I think we may be much more easily able to give you a financial-year-to-date figure than a September-to-date figure. I think we would have to take the September-to-date figure on notice.

Senator McLUCAS: Give me the figure for the financial year and then if you could take figure for September till now on notice, that would be good.

Mr Davey: In the financial year to 30 April, 122 voluntary redundancies have been accepted.

Senator McLUCAS: Thank you. How many of those have been at the SES level?

Mr Davey: None. SES do not use that mechanism. In terms of SES incentives to retire, year-to-date there have been seven.

Senator MOORE: Thank you. That is a very good answer.

Senator McLUCAS: Is that what it is really called, incentives to retire?

Prof. Halton: Yes.

Mr Davey: It is a different mechanism under the legislation.

Senator McLUCAS: How many have been at the executive level—I do not know whether to use the term, 'voluntary redundancy' or 'incentive to retire'?

Mr Davey: That is voluntary redundancy.

Prof. Halton: It is the SES that distinguishes what is different.

Mr Davey: I am going to have to take that on notice. Out of the 122, you mean?

Senator McLUCAS: Yes, please.

Mr Davey: I will take that on notice, if that is okay.

Senator McLUCAS: Then the rest would be at APS level.

Mr Stuart: Yes.

Senator McLUCAS: If I could get that split, that would be helpful.

Mr Stuart: Yes.

Senator McLUCAS: Is the structure chart on the department website up to date?

Mr Davey: It would be reasonably up to date. I have not checked it recently, but we do update it frequently.

Prof. Halton: It is Mr Davey's responsibility. He will now be checking that in the break, Senator.

Mr Stuart: It is our post restructure design. It should be reasonably up to date.

Senator McLUCAS: I would also like a breakdown of staff by level in the department. You can provide that on notice.

Mr Stuart: Yes.

Senator McLUCAS: What is the targeted number of staff reductions in the department?

Mr Stuart: Going into next year? There are really two parts to that question. There is an underlying, continuing reduction in staffing in the core department, and then there is movement of staff in from agencies. Before the budget we were on a pathway to get about 29 per cent smaller over a six-year period. We are now on a pathway to become about 24 per cent smaller over a six-year period. But we are taking on 118 staff from the three agencies that are being abolished this year. It is a kind of a mixed story. On the one hand, we have now fallen in staffing so far, during the current year, that we are actually about the right size going into next year—positioned in terms of staffing numbers. The department continues to need to make ongoing efficiencies going into next year in order to provide the staffing for new budget measures and to accommodate the agency staff and the agency work that is coming in. We think that efficiency gain required is at the 10 per cent level. It is a little bit of a complicated answer, but I am just trying to talk about the kind of underlying picture for the department.

Senator McLUCAS: I will get to the agencies that are being abolished in a moment. Are there plans for any involuntary redundancies?

Mr Stuart: No plans. I have to clarify that, Senator—I am speaking about the department.

Senator McLUCAS: So there may be some plans for involuntary redundancies out of the agencies that are coming into the department. Is that what you are saying?

Mr Stuart: Yes.

Senator McLUCAS: Where do you think that might be?

Mr Stuart: The staff of ANPHA, the Australian National Preventive Health Agency, have been given a notice.

Mr Davey: My understanding is they have been notified that they are potentially excess.

Senator McLUCAS: How many staff are in there?

Mr Davey: There are approximately 30. I would have to check the exact number for you.

Senator McLUCAS: So they have been told that they are excess to requirements?

Mr Davey: Potentially.

Senator McLUCAS: Potentially. They have not been given the opportunity to go to the business service centre?

Mr Stuart: We are working through this right now. The department is conducting an expression of interest process with the staff of ANPHA. A number will transfer to the department, somewhere in the range of 15 to 17. A number are on maternity leave and will remain on maternity leave. A number will take voluntary redundancies. At the moment I cannot tell you whether there will be, after that process, any left over. If there are any left over they will, upon the cessation of ANPHA, temporarily join the department. They then have an opportunity to be redeployed within the department or elsewhere during that period. Ultimately, if they do not find positions then there could be involuntary redundancies, hence the nature of my answer to your question.

CHAIR: What does 'staying on maternity leave' mean, Mr Stuart!

Senator McLUCAS: You just stay pregnant; it does not come out!

Mr Stuart: I am sorry. There are a small number of staff of the agency who are on maternity leave, and you cannot be given a notice while on maternity leave.

CHAIR: I see. Okay.

Senator McLUCAS: But, when they return from their mat. leave, they will be able to continue in the process that all of the other staff have been given?

Mr Davey: When staff return from maternity leave they will be, at that time, given the opportunity to find a position. That is right.

Senator McLUCAS: Has the same process been gone through for Health Workforce Australia?

Mr Stuart: Similar. I have to emphasise that the agency staff will all be dealt with by the management of those agencies under the terms of their enterprise agreements. However, the HWA staff are predominantly not public servants, so the issues in relation to them are slightly different. Nevertheless, the process being gone through is broadly similar.

Senator McLUCAS: So they are not APS employees? Is that what you are saying?

Mr Stuart: No, that is right. They are mostly not Public Service employees.

Prof. Halton: So they do not come into the department, therefore, by definition.

Senator McLUCAS: How many people are at HWA?

Mr Stuart: About 140 ASL. Some of those people will join the department, but it will be through the department hiring them rather than through Public Service transfer.

Prof. Halton: Although some of them, of course, hold return rights to the APS, so you cannot say universally that they are not public servants; some of them may actually have return rights in various places.

Senator McLUCAS: Okay. ANPHA staff have been given notice or potential notice. Has that happened to HWA staff as well?

Ms Flanagan: I look after HWA, so let me give you a bit more detail. As has already been described, staff at this particular organisation are not employed under the Public Service Act. We have put out an expression of interest—that would have gone out on Friday—asking people whether they are interested in transferring to the department. You would appreciate that, with all of these transfers, the work is actually coming to the department, even though there might be some efficiencies about that, so we still need people to do the work. I think staff are being given till Friday to put in an expression of interest and a statement of claims against positions in the department. There will be a panel that will be comprised of senior personnel from HWA and from the department to see whether we can match them into our organisation to do the work is transferring in with them. So that process is on foot. Then people will have a number of choices—for example, if they come to work in the department. We are also costing up voluntary redundancy packages so people have information about what they might get if they decided to take a voluntary redundancy. We are doing that, I think, for all of the staff in HWA, and they will be provided with those assessments so they can take that into account in their decision-making about their ongoing employment.

Senator McLUCAS: So they have one week to make this decision; is that right?

Ms Flanagan: They have one week to put in an expression of interest but, I believe, until the end of June to take the final decision—because, while we are trying to process as many assessments of what their voluntary redundancy package might be, for them to also take that into account, you would appreciate that in this town at the moment there is a lot of that work going on. So we are trying to do it as quickly as we can.

Senator MOORE: Seeing that Health Workforce Australia is in South Australia, in terms of people moving to take up positions, should they be available, is there a package available?

Ms Flanagan: Certainly, we are looking into that, I believe, to see if they choose to move to Canberra.

Senator MOORE: Can we get details of that?

Ms Flanagan: Yes. The other thing that we are saying to staff is that there will be some sort of transition. We would recognise—for example, if their kids are in school or whatever—that we would need to take into account personal circumstances. But the idea is to try to move them as quickly as possible to Canberra, noting what their personal circumstances might be.

Senator McLUCAS: There is no ability for them to work in the Adelaide office of the Department of Health?

Prof. Halton: We do not have an Adelaide office.

Senator McLUCAS: You do not have one?

Prof. Halton: We borrow a little bit of space for the small number of staff. Whether in the medium term we have some outposted function is a possibility, but we have not made any decisions about that yet.

Senator McLUCAS: I have a lot of detailed questions that I am sure Mr Davey would love to answer on notice!

Senator MOORE: Mr Davey, can we get a copy of the letter that has been sent to the people, so far, who have been identified in this process?

Mr Davey: It might be something that ANPHA would need to provide at this stage. ANPHA has provided that.

Senator MOORE: So you are not providing the letter?

Mr Davey: No.

Senator MOORE: Or to Health Workforce Australia? You are not providing any correspondence to them?

Prof. Halton: We are not their employers.

Senator MOORE: No, but I am just checking, as you oversee the overarching process; but you are not doing that. Okay.

Senator McLUCAS: With the merger of HWA and ANPHA into the department, have you identified how many positions there will be to do the work that is required to continue to be done in the department? When the two entities come into the department, how many—

Prof. Halton: That was the figure he gave you before, but I will just confirm.

Mr Stuart: Yes, the figure I gave you was 118 ASL, but that spans HWA, ANPHA and GPET.

Senator McLUCAS: What is the split between those?

Mr Stuart: I do not have that in front of me.

Senator McLUCAS: If I could get those three other figures too. Can we go to flexible funds, please? Is this the place to ask questions around the flexible funds?

Ms Flanagan: It depends on what sorts of questions you want to ask. If you want to do an overview here—

Senator McLUCAS: Yes. Can we have a list of all of the organisations that currently receive funding through each of the 18 flexible funds?

Prof. Halton: We will have to see whether the workload of that is doable, because it is a very large number.

Senator MOORE: It is not on a computer database?

Prof. Halton: Sadly, no—not all of them, not yet. We are working on it.

CHAIR: Can I just interrupt for a second. We have photographers here from AAP and *The Guardian* who have followed due process and are seeking permission to take some photos. If anyone has any objections, please let me know. Otherwise, the committee intends to allow the photographers to go ahead. Yes? Okay. Senator Moore, please go ahead.

Senator MOORE: Ms Halton, why?

Prof. Halton: Why what?

Senator MOORE: Why is there not a list of all the organisations that are getting money through the flexible funds on a computer system?

Prof. Halton: Not 'a' computer system. You will recall that we have been moving things to a computer system, to FOFMS, for some time. Not everyone has moved there yet, so things are in a number of different places. We will see what we can get you.

Senator MOORE: Good. Can we also get an update on FOFMS, because I am so fond of it!

Prof. Halton: Certainly. I love it too!

Mr Stuart: We will be done putting all our programs onto FOFMS by very close to the end of the financial year.

Senator MOORE: Like now?

Mr Stuart: All of our grant programs.

Prof. Halton: No, not quite now—soon.

Mr Stuart: We are not quite there yet, unfortunately.

Senator MOORE: Maybe when we get them all onto FOFMS, we can get the answer about all those 18 streams of flexible funds.

Mr Stuart: I am afraid there is a complication, because the flexible funds include both grants and procurements and other kinds of funding. FOFMS is all about the grants element. So, even after we have all the grants onto FOFMS, we will still not be able to use one system to produce one report about everything that is under a flexible fund because that is a very diverse range of activity.

Senator MOORE: Okay.

Senator McLUCAS: Which specific flexible funds, then, are affected by the $197 million-cut to the funds?

Ms Flanagan: That has not yet been decided. We need to go through a process. Savings are going to made to the flexible funds from 2015-16 and what we need to do is go through a process of assessment and the minister needs to take decisions on how the saving is going to be allocated across the funds generally.

Senator McLUCAS: So the decision was made to basically have a cut on a percentage basis. Is that equally applied across the funds?

Ms Flanagan: It is a little more complicated than that, as it always is with these flexible funds. I think indexation was paused on a number of flexible funds, but some flexible funds are exempted because they were subject to a separate savings exercise—for example, the Health Workforce Fund and the indigenous chronic disease fund were having separate savings made, so they were excluded from the saving that was taken to flexible funds. All flexible funds had indexation paused where it was appropriate to do so. Interestingly, for one of the flexible funds called the Medical Indemnity Fund, for example, it was not necessarily appropriate to pause indexation. There were a variety of ways in which the saving was derived, and, as I said, it will be up to the minister to then decide how to apportion that saving across the funds.

Senator McLUCAS: I understand the previous grants management unit produced the information that Senator Moore was interested in. Is that still possible?

Mr Stuart: The grants management unit has been abolished and its functions folded into other parts of the department.

Senator McLUCAS: That is a shame.

Mr Stuart: We have taken the question on notice, so we will see what we have done in the past and what we can do now.

Senator McLUCAS: I just have one more question, and it may have to be taken on notice. How many of the organisations that are funded through the flexible funds have been told that they are going to lose their funding or a proportion of their funding, and which ones have been notified of that?

Mr Stuart: As to when, it is a bit hard to answer that question, because there are activities under the flexible funds which would come to a usual end at the end of the financial year and for which there would be no expectation of ongoing funding. I am just trying to clarify your question a little bit.

Senator McLUCAS: Let us add that in as a fourth element. Which funds are terminating at the end of the financial year, which organisations will have their funding cut completely or cut by a portion as a result of the $197 million-cut and have they been notified?

Ms Flanagan: As I said, this measure does not come in until 2015-16. There have been no decisions yet taken on how to apply the cut to the flexible funds because it is a year away. There are currently organisations that we are looking at in a grants process—because, as Mr Stuart has said, for some of them there might be terminating funds for grants—that is going at the moment too look at those whose funding will terminate either at the end of June or at the end of next year. So that is a separate process that is going on at the moment; it does not relate necessarily to the decisions that need to be taken around how to apply the cuts that are coming through the flexible funds savings decision.

Senator SIEWERT: Can I just clarify something, because that is where I was going. So no organisations that get grants have yet been told whether they are getting cut?

Ms Flanagan: Not as a result of the flexible funds savings decision, but there is a process going on at the moment where government is looking at grants that terminate on 30 June.

Senator SIEWERT: Can we be clear about what that means? For those grants that terminate at the end of June, what do you mean that the government is looking at that? If they terminate, they terminate. Or is this about their expectation that they normally get refunded?

Ms Flanagan: Ms Campion might have the details on the grants process.

Mr Stuart: I am still not completely sure about the question that we are being asked, Senator.

Senator SIEWERT: I am picking up on Ms Flanagan's comments about looking at grants that are being terminated, and asking what basis they are being looked at. Is it because they normally would have been refunded?

Mr Stuart: There is a usual process when grants get towards the end of their life. I think it is important to distinguish two kinds of grants. One kind is where there has been something done as a one off, which is coming to an end and where there would not be an expectation or hope of ongoing funding. In other cases, grants may be coming towards the end of the financial year where they may have had ongoing funding in the past. The government has been going through a process of looking at all of the grants funding and looking at the merits of those grants, and that is unrelated to the savings exercise that was previously discussed. So those decisions will not reduce the size of the flexible funds; they will simply be about the minister setting policy priorities within those funds.

Senator SIEWERT: That is why I am asking. I know that there are community organisations that are getting phone calls from government, so I am trying to work out who and which grants are being told that they are either getting cut or things are not continuing. I want to know if the health department is doing the same thing.

Mr Stuart: This is a process we are going through with our ministers in terms of making decisions about what will and will not continue.

Senator SIEWERT: Have you been talking to the organisations involved, or is it purely an internal process at this stage?

Mr Stuart: We always talk to the organisations involved, but the decision making is decisions from the minister.

Senator SIEWERT: Which grants are you talking about? When you say you are talking to organisations, is that a consultation process? Are they aware that those grants may not be ongoing?

Prof. Halton: No organisation that is currently receiving a grant would be under any misapprehension about the term of their grant, because they all have contracts that are very clear about when the contract comes to an end. As Mr Stuart said, it is always the case that, as an organisation comes towards the end of that contract, either they are offered a new contract or there is a renegotiation or whatever. The process we are going through is the normal process where we would go to government and say, 'The following are towards the end of their time, what do you want to do with those ones?' So we have not been foreshadowing to organisations who are in that category any particular outcome because the government has not considered it yet.

Senator McLUCAS: It is 2 June. It is not that normal, for a program finishing on 30 June, for the department not to have had a conversation with an organisation that might have expected ongoing funding. A lot of departments made decisions about ongoing funding back in April, and that was already a bit close to time. Are you saying that you have not had conversations with organisations that might have expected to receive continued funding in the next financial year?

Prof. Halton: We have had our regular conversations with those organisations. What we have not indicated to them is any decision in relation to that funding, because as yet those decisions have not been taken. I could point

you to a multitude of examples of where decisions have been taken late in the past—this is not something which has never occurred in the past.

Senator SIEWERT: That does not make it right.

Senator CAROL BROWN: We hear what you want to do with them but are you making recommendations about these grants to the minister?

Mr Stuart: Yes, as part of the normal process of advising the minister about grants. You referred to some other portfolios advising agencies during April and before; we have been doing that too. The ministers have been making decisions progressively over a period and a range of agencies have been advised, and there is a small number outstanding that we are working through now.

Senator SIEWERT: Do you mean a small number of grant programs or organisations yet to be told?

Mr Stuart: Yes.

Senator SIEWERT: Both?

Mr Stuart: Yes.

Senator SIEWERT: Can we get a list of those programs and those grants? I realise it is inappropriate to ask for the organisations or that you are unlikely to tell me, but can you get a list of those granting areas that are still being negotiated?

Mr Stuart: We will have to take that on notice.

Senator McLUCAS: The Department of Human Services and the Department of Health were progressing a concept to link, de-identify and store MBS data and PBS claims data to better inform health and service delivery policy development. It was a proposal that was proposed by Professor Fiona Stanley, is my recollection, and there was a desire to progress this work. Is that continuing?

Prof. Halton: I actually do not know the particular thing you are referring to, Senator.

Senator McLUCAS: That is terribly disappointing. Thank you.

Senator DI NATALE: Just a question again about the medical research fund—if I am right in reading the budget papers we have got $10 billion over the forward estimates and $20 billion over six years. Over the forward estimates $3.5 billion will come from the co-pay, $1.8 billion from the cuts to hospitals, $1.3 billion from the PBS co-pay and changing other thresholds and $1.7 billion from freezing the MBS indexation measures as well as a host of other smaller things. That is over $10 billion over the forward estimates?

Ms Flanagan: That would sound about right. I do not know whether you were here but we have agreed to do, in effect, the maths that you have just done, adding up all the savings measures.

Senator DI NATALE: To put some parameters on it, I think it is about $10 billion and I think in the budget papers the return was something like $276 million to medical research over the four years?

Prof. Halton: This is in terms of the interest that would be brought down?

Senator DI NATALE: Yes.

Prof. Halton: Remembering that it is a capital preserved fund?

Senator DI NATALE: That is correct. That is my point—we are not putting $20 billion into medical research, are we? Statements have been made to that effect but we are not actually putting $20 billion into medical research; we are putting it into a fund and a—

Prof. Halton: Capital protected, yes.

Senator DI NATALE: Yes and in fact the return in terms of medical research rather than being $10 billion over the forward estimates is only $276 million as projected in the budget papers?

Prof. Halton: I do not know the reference that you are making to how much is going to be put into how much is going to be put into medical research; I cannot make a comment about that.

Senator DI NATALE: The budget papers.

Prof. Halton: With the money that will be put aside in terms of capital, it has been decided that the drawdown in terms of the interest, the investment income, will be made in fact before the fund reaches maturity.

Senator DI NATALE: That is correct.

Prof. Halton: The amount that will be drawn from the interest and from the income that is derived from the quantum that is in the fund at any point, noting that the fund, the capital—

Senator DI NATALE: Will increase over time.

Prof. Halton: Yes, and will be capped at $20 billion, do you understand?

Senator DI NATALE: Yes. So the amounts that are shown are the amounts that have been decided to be drawn out, assuming that the fund makes money—and we all assume it will—et cetera.

Senator DI NATALE: I suppose the point I am making is: there have been statements made by members of government that we are putting $20 billion into medical research. I just want to clarify that is not the case, that we are not investing those funds into medical research. Is that correct?

Senator Nash: The comments you are making, I would have to check, but indeed we are talking about that as an investment. It is really important to note the long-term sustainability of this. One of the reasons we have done this, in the capital preserved fund, so there will be ongoing funding over time assured so that we can, long term, continue to invest in medical research, which I am sure is something very important to you. In making the comparison, I take your point. We have $10 billion that is going, give or take, in there now, but the priority for the government was: how do we ensure—long term—we have certainty and sustainability for investment into medical research?

Senator DI NATALE: I understand that. I just want some clarity. If we are returning, as projected in the budget papers, $276 million from that $10 million investment, and the co-pay is worth $5, if you are saying the return is about 2.7 per cent of that $5, the 2.7 per cent—which is about 13 cents—is actually what will be directly funding medical research. The rest of that money will be going into a fund that is locked away, as part of the capital. Is that correct?

Prof. Halton: I am having trouble following the numbers, so I am not making any comment on those numbers, because I do not follow them. The reality is—

Senator DI NATALE: Would you like to elaborate on those numbers?

CHAIR: No, we do not have time for you to elaborate.

Prof. Halton: The reality is that the dividend that will come from the fund will be paid every year thereafter. I think we are saying about $1 billion a year. So we are saying that when the fund is mature $1 billion in each and every year will go to medical research. The amount that you will derive from the capital invested, depending on which year you add it up—but by the time you are five years of maturity you are at $5 billion. Depending on how well the guardians—dreadful term—do, in terms of the investment strategy, it could well be more than that.

Senator CAROL BROWN: Professor Halton, when does your contract expire?

Prof. Halton: We do not have contracts; we are on formal appointments from the government. They are not contracts.

Senator CAROL BROWN: When does your appointment expire?

Prof. Halton: 1 July.

Senator CAROL BROWN: This year.

Prof. Halton: Correct; as determined by the former government.

CHAIR: Are you waiting for the grants process, Ms Halton?

Prof. Halton: Yes, maybe I am.

Senator CAROL BROWN: So it has not been extended; that is just your normal appointment.

Prof. Halton: That is right.

Senator McLUCAS: How many questions on notice were received, by the committee, by the agreed date?

Prof. Halton: Of the ones received by us by the agreed date, noting that apparently there are a whole number that were lost.

Senator McLUCAS: I do not know about that.

Prof. Halton: Yes. There are a whole number—

Senator McLUCAS: Can you explain that to me? I do not understand.

Prof. Halton: I am sure the officers can. My understanding is that we only received a swag of questions very recently.

Witness interjecting—

Prof. Halton: I stand to be corrected on that.

Mr Cotterell: The department received 366 questions on notice and we answered 245 on time, 99 within one month of the hearing.

Senator McLUCAS: And 25 at a quarter to 10 this morning, or is it 15?

Mr Cotterell: It was 15 on Friday afternoon, I understand.

Senator McLUCAS: Are there any outstanding?

Mr Cotterell: There are none outstanding.

Senator McLUCAS: Is there a reason that the 15 appeared as late as last Friday?

Mr Cotterell: The time taken to answer the questions reflects a whole series of factors, including the number, the breadth, and the complexity of the questions asked and the effort needed across the department to respond in the context of other demands on the department at the time.

Senator McLUCAS: Were in fact questions lost, so to speak, or misplaced?

Prof. Halton: There may have been confusion. There is a group of questions that I think may have been questions from the Senate, not Senate estimates. I apologise about that. We had a whole series of things appear at the end of last week which had disappeared somewhere in the aether.

Senator McLUCAS: Could I also have, Mr Cotterell, the date at which that last batch of 15 was sent to the minister's office for approval?

Prof. Halton: We will take that on notice.

Mr Cotterell: We do not have that information.

Senator SMITH: Just following on from Senator McLucas' comments, if my math is correct—and I admit it is not a strength of mine—that is almost 70 per cent of questions answered?

Mr Cotterell: Sixty-eight per cent.

Senator SMITH: Sixty-eight per cent—I surprised myself. Of course, these things can be misleading unless seen in comparison with other points in time. Could you provide me with an analysis of responses to questions on time for the June 2013 Senate estimates. Do you have that available there?

Mr Cotterell: There were 241 questions on notice taken at that estimates and 13 per cent answered on time.

CHAIR: And fewer questions.

Senator SMITH: So just that I have it clear, Mr Cotterell: 68 per cent of questions answered on time for this Senate estimates, and for the June 2013 Senate estimates the response was 13 per cent?

Mr Cotterell: That is right. One thing that the overall numbers will not give you is the complexity of the questions. Sometimes they are multipart questions.

Proceedings suspended from 10:37 to 10:50

CHAIR: The committee will resume with outcome 4, Acute care.

Senator Nash: Madam Chair, we just might wait a minute for some officials. I think they might be of assistance to Senator McLucas.

CHAIR: We did say we would resume at 10 to 11.

Senator McLUCAS: Could the department please explain the changes to funding arrangements and the guarantees that were in place for public hospitals, comparing the arrangements as at August 2013 that would have been implemented over the life of the agreement with the states and territories with the new arrangements around public hospital funding and pricing announced by the government.

Mr Maskell-Knight: The changes the government announced in the budget were to not make payments under the guarantee arrangements of the National Health Reform Agreement and to change the basis of the payments from 2017-18. Taking the guarantee payments first, under the National Health Reform Agreement the states were guaranteed a certain amount of money over and above what they would have received under the national healthcare specific purpose payment. Essentially, the mechanism was that there would be activity based funding. If in any year the amount paid for activity based funding was less than a certain amount in excess of the former healthcare SPP, the difference would be paid to the states under what was called top-up funding. The government has now decided not to pay that top-up funding if indeed it would have become available under the arrangements. The effect of that is to save $217 million in 2014-15, $260.5 million in 2015-16 and $133.4 million in 2016-17. From 2017-18, the government has announced it will be indexing its contribution to public hospitals by population and CPI. The difference between what would have been paid and what is now expected is a saving of $1,000,162.8 million.

Senator McLUCAS: And that figure of $1.1 billion is just for that year?

Mr Maskell-Knight: Yes.

Senator McLUCAS: Thank you. Just for the record and the committee, would you explain the national efficient pricing arrangements and how they operated. I know you gave us a fairly good overview there, but how did they operate in practice?

Mr Maskell-Knight: The Independent Hospital Pricing Authority determines a national efficient price. The Commonwealth's contribution for a year is then calculated by the administrator of the national health funding pool, having regard to the estimated volumes of hospital services and the national efficient price.

Senator McLUCAS: I think you have explained that the government is walking away from that price-setting process.

Mr Maskell-Knight: From 2017-18 the contribution will be determined by having regard to indexation factors rather than activity.

Senator McLUCAS: I will come back to the indexation in a moment. What is the government's commitment to retaining the Independent Hospital Pricing Authority?

Ms Flanagan: You would probably be aware that in the cross-government decision taken about smaller government there is an intention to consult with the states and territories to amalgamate a number of agencies, including the Independent Hospital Pricing Authority. The intention is that the national efficient price arrangements, the performance arrangements, et cetera, will of course continue in that merged body, a new productivity and performance commission. States and territories, such as Victoria, have been doing national efficient pricing for a long time now and this is now being rolled out nationally across the country in terms of all states and territories using national efficient pricing. The intention is that this work will continue for the next three years and I would imagine that the states and territories will find it valuable going into the future as well because this will be a mechanism by which they price their hospitals over time.

Senator McLUCAS: Can I just go back then to Mr Maskell-Knight's earlier evidence about the savings—$217,266.5173 over the three forward years. If we are going to retain a notion of the national efficient price—I think that is what I am being told, to keep the principle of the national efficient price—how do you arrive at those figures?

Mr Maskell-Knight: That is the difference between what the National Health Reform Agreement said would be paid on top of the former specific purpose payment and what is now expected to be paid based on the level of activity that hospitals will deliver.

Senator McLUCAS: An amount of money was allocated under the former agreement—these are funds that are almost like an incentive to get states and territory hospitals to get to the national efficient price. Is that an understanding of it?

Mr Maskell-Knight: I suppose a way of looking at the former agreement was that the amount of money on top of the specific purpose payment was guaranteed if the states were able to achieve efficiencies through hospital management. It was essentially inequitable in one sense that the more efficient they were, the less money they got paid. So the amount of money that they were to receive was guaranteed under the agreement.

Senator McLUCAS: That figure that was agreed was like a base level funding prior to the agreement coming into place?

Mr Maskell-Knight: The amount of money, which is guaranteed, was essentially $16.4 billion over six years, in addition to what would have been paid under the national healthcare specific purpose payment.

Senator McLUCAS: Ms Flanagan, what functions of the Independent Hospital Pricing Authority will be continued to be performed, either within the Department of Health or by another entity?

Ms Flanagan: It will be by another entity—that is the intention. We are going to go around and talk to the states and territories about what functions they wish as a group to see continue to be performed in this space. As I said, for the next three years funding from the Commonwealth will be determined based on an efficient price. That work needs to continue.

Senator McLUCAS: Is there a view from the department about what activities should be continued with? Rather than just asking the states, 'What do you think we should do,' surely there would be a view held by the department about what activities should be continued.

Ms Flanagan: They are the activities that the Independent Hospital Pricing Authority currently does. It has been set out what those functions are, and we would expect them to continue to perform them.

Senator McLUCAS: Why are we having a conversation with the states and territories then?

Ms Flanagan: Because we are merging a number of bodies. For example, we are merging the Independent Hospital Pricing Authority, the National Health Performance Authority, the AHW, the funding administrator and the funding body, as well as the safety and quality commission. That is what we are going to be having—

Senator McLUCAS: Sorry; I was just talking about the current activities of IPHA.

Ms Flanagan: Yes, but the conversation we are going to have with the states and territories is about the fact that we are merging a range of bodies into a single productivity commission. That is what the conversation is going to be about: how do we actually achieve that? For example, there are joint funding arrangements for some of the bodies but not for others. The states and territories fund jointly, for example, the work that is done by the safety and quality commission. So that is going to be the conversation.

Senator McLUCAS: So the conversation is not about activity; it is about how it is funded?

Ms Flanagan: Yes.

Senator McLUCAS: I cannot understand why the Commonwealth government would agree to move away from an arrangement that allows an understanding of the activities and the pricing of activities that are going to happen in a hospital. Surely, we would always want to retain that knowledge and process of determining a price.

Ms Flanagan: I think there is a difference between having that knowledge and continuing with that knowledge and the intention of the Commonwealth government to fund something on a different basis. There is a change in the way things are to be funded from 2017-18, but the work of efficiently pricing hospitals is something that is very important.

Senator McLUCAS: I hope so. Moving, then, to 2017-18, when the really big cuts start, Mr Maskell-Knight, I think you said that there would be an indexation based on population and on CPI. What is the rationale for those to be the indexing elements?

Mr Maskell-Knight: I think you are going to decisions the government might have taken, rather than something I could answer.

Senator McLUCAS: Yes. Minister, maybe that is a question you can answer? Why is the government moving to an indexing arrangement in 2017-18 that will be on the basis of population and CPI? What is the rationale for that?

Senator Nash: The rationale—I think we have been very clear about this—is about making the health system sustainable. As you would be well aware, over the forward estimates there is actually an increase to public hospitals, from $14 billion to $18.9 billion over that time.

Senator McLUCAS: That is not the question I asked.

Senator Nash: I know. We have got all day.

Senator McLUCAS: I am interested in knowing what the rationale is.

Senator Nash: I have only have 30 seconds. Give me a chance; I am getting there. It was a decision of government to change the arrangements to ensure that we have got a sustainable health system into the future. As has been indicated, there is obviously a view from the opposition that the existing arrangements should have stood. That comes, as I understand it, with about a $15 billion price tag, so it would be interesting to see how your leader could confirm how that would be paid for at the time.

Senator McLUCAS: It is very interesting but not the answer to the question.

Senator Nash: No, I am answering the question—because it is about making the system sustainable. We know that we have to make some cuts. We know that the previous government has left us with a trajectory to a debt of $667 billion, so we have had to make some tough decisions.

Senator McLUCAS: Okay. So why are you indexing on the basis of population and CPI? Give me the rationale for a medical pricing model that would tell you that population and CPI are the real drivers of costs in health.

Senator Nash: That was a decision of government as the most appropriate way forward.

Senator McLUCAS: And the rationale for that decision is?

Senator Nash: I am sorry?

Senator McLUCAS: Why did you pick population and CPI? There are lots of other ways you can index costs into the future. This committee has had long conversations over many years about how CPI cannot be applied to health costs; health costs grow at a different rate to CPI. We have also had conversations about the costs of

delivering health in regional and rural areas and the fact that some states and territories have much more regional and rural area, so population by itself is not an indicator of real cost.

Senator Nash: My understanding is that those arrangements do apply across other areas also. I am well aware, as you would know, of the differences between metropolitan and rural areas when it comes to health funding. The block funding, as I understand it, stays, but—I will correct this if I am incorrect—from 2017-18 onwards it will then be a matter for the states, and I would hope that the states would focus to ensure that we have the proper health delivery into regional areas that we need.

Senator McLUCAS: So, just vacate the space; the states will fix it up?

Senator Nash: I am sorry, Senator; what is the question?

Senator McLUCAS: You are saying: just vacate the space, move away, and the states will find their own way of funding their hospitals.

Senator Nash: As you are well aware, it primarily is a state responsibility, so we would expect—

Senator McLUCAS: It is going to be more and more.

Senator Nash: We would expect that the states would adhere to those responsibilities in that manner.

Senator McLUCAS: And removing, frankly, $80 billion out of health is something that can be accommodated?

Senator Nash: We are not removing $80 billion out of health.

Senator McLUCAS: Sorry, only $50 billion!

Senator Nash: We are increasing hospital funding over the forward estimates. As I indicated earlier, we are going from $14 billion to $18.9 billion in terms of the Commonwealth spend on public hospitals. I fail to see how that is a cut.

Senator McLUCAS: Your own budget papers show it very, very clearly. However—

Senator Nash: Perhaps I can assist the committee. We are talking about Budget Paper No. 1, Budget Strategy and Outlook 2014-15, page 6-11. Against 'Assistance to the states for public hospitals', there is $13.845 billion, rising in 2014-15 to $15.116 billion; in 2015-16, $16.551 billion—

CHAIR: They are all billions, I take it, Minister!

Senator Nash: They are all billions

Senator McLUCAS: Yes, I can read the other papers to you as well. Let's get on with questions.

Senator Nash: In 2015-16, $16.551 billion; in 2016-17 projections, $18.095 billion; in 2017-18, $18.872 billion. So, clearly in the budget papers, that is an increase.

Senator McLUCAS: Just in this area, the cuts are, I estimate, over $1.8 billion—just in this area.

Senator Nash: Senator, I am not—

Senator McLUCAS: However, let us go to the conversation with the states and territories.

CHAIR: Senator, you need to allow the minister to respond to that statement.

Senator Nash: Senator, I think we need to be very clear about this. I am not sure what you are reading from that is indicating a cut. Perhaps you would like to provide it to the committee.

Senator McLUCAS: Budget Paper No. 2, Budget Measures, page 126.

Senator Nash: I can reiterate, for the committee, that those figures stand in the budget papers. Indeed, there is a $5 billion increase from the Commonwealth to the states and territories over the forward estimates relating to public hospital expenditure.

CHAIR: Senator McLucas, as a matter of courtesy, if you are not satisfied with the minister's answer, you are more than welcome to ask another question, but could you please let the minister finish her answer before you do ask a new question.

Senator McLUCAS: I will be more courteous. So how are we going to negotiate this with the states and territories? What is the process for that?

Senator Nash: That will be a matter for the ministers to take forward.

Senator McLUCAS: That is what I am asking.

Senator Nash: That is right. Well, I am not the minister responsible; I am very happy to take that on notice for you.

Senator McLUCAS: Maybe I could ask the department: is there a plan for renegotiating these agreements with states and territories?

Prof. Halton: At this point, I can tell you that the minister will be meeting with his state and territory colleagues in the next few weeks. I think, until that meeting has occurred, I cannot make any other comment.

Senator McLUCAS: That would be done on a bilateral or multilateral basis?

Prof. Halton: The meeting would be on a multilateral basis.

Senator McLUCAS: When were the states and territories informed of the proposed changes to hospital funding arrangements?

Ms Flanagan: They were informed on budget day.

Senator McLUCAS: And there was no discussion with them prior to budget day?

Ms Flanagan: No. Interestingly, they do not talk about their budgets with us either!

Senator McLUCAS: I understand that.

Senator Moore interjecting—

CHAIR: Senator McLucas, could you make this your last question for now. There will be an opportunity for more questions later, but there are about six senators waiting to ask questions.

Senator McLUCAS: Has any state or territory been informed of the estimates of the financial impacts of the proposed revisions to funding arrangements that they can expect under the changed arrangements and the change that represents compared with previous funding?

Prof. Halton: That is actually a question for the Treasury. As you know, under the arrangements put in place under the previous government the transfer of moneys from the Commonwealth to the states in respect of hospitals are actually managed by the Treasury.

Senator McLUCAS: Has the Department of Health done that analysis and those figures?

Prof. Halton: We do not do that analysis. That is actually organised by the Treasury. They are responsible for those numbers, not us.

Senator DI NATALE: I am interested in the changes to the Commonwealth-state hospital relations. Do we have any estimate about the number of beds that will close as a result of these cuts?

Prof. Halton: No.

Senator DI NATALE: Are you aware of any state hospitals that have announced that they are going to be cutting services, closing beds?

Prof. Halton: I will look to the officers in respect of that, Senator.

Ms Anderson: There has been some media coverage of that. We have not been fully advised of that.

Senator DI NATALE: So you have only just read about it in the papers. You have not been advised at all.

Ms Anderson: That is correct.

Senator DI NATALE: Has any representation been made from any state health department or any other government agency?

Ms Anderson: No, I do not believe so.

Senator DI NATALE: Can you break down, by state, how much money is going to be taken out from each state?

Prof. Halton: I think that was the question we just answered for Senator McLucas.

Senator DI NATALE: I am sorry; I missed that. The answer was—on notice?

Prof. Halton: It is a question for the Treasury.

Senator DI NATALE: Why was that a question for Treasury?

Prof. Halton: Because under the previous government the funding in respect of hospitals, calculation and payment thereof was actually moved from my portfolio to the Treasury. They are responsible for these issues and I am not in a position to answer those questions.

Senator DI NATALE: One of the statements in the budget is that the funding changes have been implemented in order to reduce inefficiencies. What inefficiencies are there in the system that needed to be addressed?

Prof. Halton: Where are you reading that from, Senator?

Senator DI NATALE: The budget measure claims that states are best placed to reduce possible inefficiencies. I understand that was in the budget papers.

Ms Anderson: One of the areas that goes to is the removal of the guarantees. Mr Maskell-Knight explained the notion of guarantees, which was in the initial National Health Reform Agreement. The guaranteed additional funding—funding over and above that which government would contribute towards activity in public hospitals—actually dampened the efficiency signal which is embedded in that contribution by virtue of—

Senator DI NATALE: Could you just explain that?

Ms Anderson: By virtue of the use of the national efficient price there is a certain signal that is transmitted to state and territory departments of health and, through them, to local hospital networks and public hospitals. That is the price that is expected to be the average of all public hospital costs. The additional funding was dampening that signal. It was, if you like, taking a certain degree of pressure off the public hospital system—

Senator DI NATALE: You are suggesting they may not have been performing a particular activity at a particular price and would have been compensated for through the guarantee. If they were inefficient, they would have got money anyway through a block grant rather than through activity based funding.

Ms Anderson: There was additional money being provided to states and territories over and above the national efficient price, which could have been used to pay for inefficiency.

Senator DI NATALE: Is that how all the money was distributed? With the guarantee, is there any evidence to suggest that money was going to hospitals that were performing activities at a cost greater than the efficient price?

Mr Maskell-Knight: I think the answer has got to be yes.

Senator DI NATALE: Just explain that—I am genuinely interested in how that works?

Mr Maskell-Knight: The Commonwealth's contribution was based on the national efficient price. Under the agreement it was up to states and territories to make up the difference between costs and what the Commonwealth contribution was.

Senator DI NATALE: Can you say that again?

Mr Maskell-Knight: The Commonwealth contribution was based on the national efficient price—that is not quite true because 2013-14 was essentially a fixed block funding arrangement, but leave that to one side for the moment. The Commonwealth was paying a share of the national efficient price which on average across the country is about 35 per cent. But if you are running a hospital that only costs 90 per cent the state gets the extra 10 per cent; if you are running a hospital that costs 110 per cent the state has to ante-up the extra.

Senator DI NATALE: What I do not understand is that that money has effectively been taken out of the system, and what assistance has been given to those hospitals that are deemed to be inefficient?

Mr Maskell-Knight: That is a matter for the states systems to manage and to equalise between efficient hospitals and inefficient ones just as they do now.

Senator DI NATALE: Is that not a big jolt to the system? You are basically ripping billions of dollars out of the system on the pretext that some hospitals are inefficient. Effectively, patients are going to be left without getting access to those services because you have got a concern about the fact that some hospitals are being rewarded for being inefficient.

Ms Anderson: We continue to pay for a share of every single public hospital service delivered. So the government has not withdrawn funds from activity which is delivered.

Senator DI NATALE: But was that money spent on public hospitals, the guarantee?

Ms Anderson: We have not yet moved into the guarantee period.

Senator DI NATALE: How much of that money that was available would have been spent?

Mr Maskell-Knight: We estimate the saving in this year—we read that number out before—is $217 million in the 2014-15 year, which would have been paid as a guarantee payment. Under the agreement, A71 says:

… states and territories may use top-up funding—

that is, the $217 million—

for any health service that will assist in ameliorating the growth in demand for hospital services, including chronic disease management programs, preventive health programs, mental health programs, hospital admission avoidance programs, hospital early discharge programs, or other health services as jointly agreed by the Commonwealth and the relevant state …

Senator DI NATALE: Don't hospitals already have an incentive to reduce inefficiencies by virtue of activity based funding? Is that incentive not built into the system already?

Prof. Halton: That is where we get to a much more complex space. Go on, Mr Maskell-Knight.

Mr Maskell-Knight: I do not know where to start, Secretary. Yes there is an incentive at a hospital level but it is contingent on how the state decides to run its hospitals as well. As long as we are paying 35 per cent and the states are paying 65 per cent, it is up to the states as system managers to encourage and incentivise—a ghastly word!—hospitals in the ways they think appropriate.

Senator DI NATALE: That is my point—that is already inherent within the system. Why does taking money out of the system increase the incentive to do that?

Mr Maskell-Knight: It increases the incentives for the states as system managers to improve things.

Senator DI NATALE: But that incentive already exists by virtue of activity based funding, does it not?

Mr Maskell-Knight: We are not saying there is not an incentive; we are saying this will strengthen it.

Senator DI NATALE: What a ridiculous argument—you could cut the hospital budget by 50 per cent, and of course there is going to be a greater incentive. You could cut it by 90 per cent.

Mr Maskell-Knight: To be clear, we are talking about $217 million in 2014-15 out of total funding of $15.1 billion.

Senator DI NATALE: What about over the forward estimates?

Mr Maskell-Knight: Over the forward estimates excluding 2017-18 it is very similar numbers; it is a small proportion of the total.

Senator DI NATALE: I have got $1.8 billion over the next four years.

Mr Maskell-Knight: Which would be probably less than 2½ per cent.

Senator DI NATALE: You are saying it is there to increase efficiencies within the state system, and now you are saying it is such a small proportion it is insignificant. So how on earth is it going to increase efficiencies?

Prof. Halton: You could draw a parallel to the efficiency dividend, which we have been delivering for as many years as I can remember. Let me tell you, that drives efficiency. Every day, we look at efficiencies. You ask division heads in my department about how they are required to drive efficiency to deliver the government's business in a more effective and efficient way. It focuses the mind in a very particular way.

Senator DI NATALE: It certainly focuses the mind of a patient who is waiting to have their hip done and is going to have to wait another few months because there is less money in the system.

Prof. Halton: Alternatively, the administrators of those hospitals could look to see at what price a hip replacement could be done in one hospital versus another. I suspect that Dr Sherbon could give you some practical examples of the variation in the cost of doing exactly the same procedure across very similar hospitals.

Senator DI NATALE: I am aware of that. The question is: what is the solution to that? Is it simply to starve the hospitals of funding? That is really the point here. I am not disputing the fact that there are some hospitals that may be doing an activity at a lower price than others—and there are questions around why that should happen—but it is the mechanism through which to respond to that. Clearly, on the one hand, you are saying that there is an incentive because the Commonwealth gives too much money; on the other hand, you are saying, 'Actually, it's such a small proportion, it does not matter.' Both arguments cannot be true.

Prof. Halton: I think that is probably an unfair characterisation of what the officer actually said. The reality is, at 2½ per cent, there is incentive. I know that on a day-to-day basis in terms of running my portfolio. The reality is, though, that, compared to the example you were using, which is 50 per cent, it is an incentive but it is not so material that it is going to cut a waiting list in half. The reality is that the costs for, for example, hip replacements vary hugely across the country. I am sorry; but, in similar kinds of hospitals, there is not a particularly good argument as to why the variation in costs should be so great. So your point is correct. You need a variety of strategies, one of which is to make it transparent to people in various parts of the system how they are performing compared to how other people are performing, and that is one of the things we have been doing.

Senator DI NATALE: Sure. But that is not what we are talking about here. I agree with you on that, but we are talking about the mechanism, which is the withdrawal of funds—

Prof. Halton: This particular—

Senator DI NATALE: This mechanism—which is the mechanism we are talking about—is the withdrawal of funds. It may not impact waiting lists by half, but it is going to have an impact on services; you would concede that.

Prof. Halton: I do not necessarily concede that. The reality is you would expect people to be able to drive that level of efficiency, and these are large businesses; they are large production shops. I actually do not accept that you cannot drive that amount of efficiency.

Senator DI NATALE: With incentives already built in? Can I ask you about tying the hospital funding to CPI. We know that CPI represents the cost of goods and not wages, which grow faster than CPI. We have a different measure for measuring health inflation. Why would you tie the increase in hospital funding to CPI when we have health inflation which is measured in a totally different way by the ABS? It is going to mean a decline in the real funds available to hospitals. Why was CPI chosen?

Prof. Halton: I think we just answered this question from Senator McLucas, and I think the minister has indicated two things: (1) this index rate is being applied across a number of Commonwealth-state programs and (2) it was a decision of government. We gave Senator McLucas a longish answer about that.

Senator DI NATALE: I have a number of questions if we have time. But perhaps just a quick question: one of the huge problems within the sector at the moment is the Commonwealth-state blame game that goes on. By moving to this model, how are we going to not return to the old days where state governments blamed Commonwealth governments, and vice versa?

Prof. Halton: You are now asking us for an opinion, and you know my reflexive answer on that. But if the minister would chose to answer—

Senator DI NATALE: No, not really an opinion. I am just interested to know how it is that we have transparency on Commonwealth and state responsibilities, given that we have changed the way we are going to fund hospitals.

Senator Nash: I would assume that the states and territories will act responsibly, as will the Commonwealth, in determining the way forward by 2017-18.

Senator DI NATALE: They did not before we had these arrangements. What makes you optimistic that we are suddenly going to see a road to Damascus conversion?

Senator Nash: I am very optimistic that that will occur.

Senator DI NATALE: What do you base your optimism on?

Senator Nash: I am certainly not basing it on what happened in the past, but I think that there will be cooperative arrangements between the states, territories and Commonwealth.

Senator SESELJA: I just wanted to follow on from the minister's answer earlier in terms of the increase in health funding overall. I wanted to maybe get some more of a breakdown on that. It might start with the ACT, in terms of what the budget means for hospital funding in the ACT. Are we going to see an increase in hospital funding over the coming years?

Mr Maskell-Knight: As the secretary indicated earlier, Treasury is best placed to answer state-by-state allocations.

Senator SESELJA: Sorry, I was here, but I must have missed that. I apologise. We will have to put those questions to Treasury in terms of those increases.

Prof. Halton: We will do that on Wednesday.

Senator SESELJA: If I could then perhaps ask another ACT-based funding that is not on the funding, necessarily, but on the agreement and some of the statistics. Is that appropriate to be asking here?

Prof. Halton: Try away. We will see how we go.

Senator SESELJA: On the National Health Performance Authority and the document *Time patients spent in emergency departments in 2012 and 2013*, are we able to ask a couple of questions around that?

Prof. Halton: Yes.

Senator SESELJA: I do not want to go across Australia on this. Other senators might have specific questions around particular states. Overall, we saw some improvements in some hospitals, but we saw a lot of the targets failing to be met. In the ACT, specifically, we saw in January to December 2012 a failure at both Calvary Public Hospital and Canberra Hospital of meeting the target of 64 per cent. In January to December 2013, we saw Calvary meeting the target by getting to 66 per cent, but Canberra failing at 54 per cent. I am just interested in you outlining for us what is the impact of the failure to reach those targets, in this case by the ACT and certainly in both 2013 and 2013?

Ms Anderson: Those targets are actually established within the National Health Reform Agreement. The National Emergency Access Target is a measure of patients waiting times in EDs, as you would be aware. These

targets are the proportion of patients who wait four hours or less to be treated, admitted, discharged or referred. It is correct that the ACT's results are lower than the target.

That data is considered by the COAG Reform Council and advice is provided to government on achievement against targets, and then the Commonwealth government makes a decision about the allocation of reward funding against the proportion of achievement. The Commonwealth government has not yet advised of its final decision in relation to receipt of award funding for 2012 or 2013. Award funding will be paid to eligible jurisdictions and those decisions will be advised as soon as they are made.

Senator SESELJA: So the reward funding is determined by whether or not the targets are met?

Ms Anderson: Yes. There is a stepped target for NEAT. The target is 90 per cent by 2015, but for each jurisdictions there were negotiated interim targets stepped out by year. They incrementally increase towards that 90 per cent. That data that you read out would be assessed against the target for the relevant year.

Senator SESELJA: So the rate of improvement would be considered, as well as whether the actual target is met or is it just whether the target is met?

Ms Anderson: It performs against the target for that year.

Senator SESELJA: Is it if you get close or if you get somewhere in the ballpark there is some reward funding? In this case with the ACT, you have got one hospital reaching it and not the other hospital. Obviously, overall, it is not reaching it. Is there still the potential to get part of the reward funding under the formula?

Ms Anderson: If the target is not achieved, there is the capacity for rolling forward the amount that is not paid within a particular year.

Senator SESELJA: You said that the reward funding has not been assessed yet for those two years that we are referring to.

Ms Anderson: The 2012 performance has been assessed by the COAG Reform Council. The government has not yet advised of a decision in relation to the payment of reward funding.

Senator SESELJA: For each of those years, what is the potential reward funding for the ACT if they were to meet all of their targets?

Ms Anderson: For the ACT, the reward funding available for 2012 performance is $800,000.

Senator SESELJA: It is a new one. In 2013?

Ms Anderson: I think it would be the same, but I will need to check that.

Senator SESELJA: The ACT potentially loses all of that or part of that, depending on the assessment process. But it has not yet been finalised.

Ms Anderson: That is correct.

Senator PERIS: My questions are around the Palmerston hospital. Could you please advise how much has already been provided to the Northern Territory government and the breakdown of the funding over the forward estimates for over the next three to four years? That is the $110 million that was committed.

Prof. Halton: I think there is a question on notice in relation to this issue. We will just find the reference for you.

Ms Anderson: Could you repeat the question? I am not sure that we have that information at hand.

Senator PERIS: Last time at estimates it was confirmed that the Commonwealth government had committed $110 million to the Palmerston hospital. Can you advise how much has already been provided to the Northern Territory government and the breakdown over the forward estimates?

Ms Flanagan: In terms of the question that we did answer—which is 169; it might be that we need to update these figures—and of the funds when we answered the question, the Northern Territory had been paid $1 million to date at that time. We will just check whether the officers can update whether there are further payments being made. These were the questions that were asked on 26 February. Unfortunately, it does not say, 'As of April.' But we will double-check that. These funds had been provided for the delivery of a project plan, as provided in the funding agreement. I think last time you did ask whether it was a scoping study.

Senator PERIS: Yes.

Ms Flanagan: This was actually for a project plan, rather than a scoping study.

Senator MOORE: Is it one step closer to a scoping study?

Ms Flanagan: I think it might be that we had a re-scoping study.

Senator MOORE: That did not help at all. Is that what a project plan is?

Ms Flanagan: I can tell you that the scoping study has been released by the Northern Territory government on 20 February 2014 and can be found at the following website address.

Senator PERIS: Yes.

Ms Flanagan: It is health.nt.gov.au/Palmerston_regional_hospital/index.aspx.

Ms Anderson: I do have further information. In relation to Palmerston, there has been no additional payment. The funding is cash flowed over three financial years for that $70 million in 2014-15 to 2016-17.

Senator PERIS: How much has that?

Ms Anderson: There is the $70 million, but also the additional $40 million. That is cash flowed over two years: 2014-15 and 2015-16. There are no additional payments yet, with the first payments expected next financial year.

Senator PERIS: Okay. In the forward estimates, there is $40 million over the next two years. Can you give me the exact breakdown of what is committed in the forward estimates now?

Ms Anderson: I would be pleased to take that on notice. That is a detail that is not available in the papers here.

Senator PERIS: Okay.

Ms Flanagan: Senator Moore, I have been advised that the question was provided to the committee on 22 April.

Senator MOORE: Okay. We have not got it yet.

Ms Flanagan: So it is fairly recent information.

CHAIR: Do you have more questions on Palmerston, Senator Peris?

Senator PERIS: I do. On 19 May, the Northern Territory Chief Minister raised concerns about the future of Palmerston hospital, given the Commonwealth health cuts. Has there been any discussion between the Commonwealth government and the Northern Territory government?

Ms Flanagan: Not at a department-to-department level, no.

Prof. Halton: Not that we are aware of.

Senator PERIS: Minister?

Senator Nash: Not that I am aware of, Senator, but I will take that on notice for you.

Senator PERIS: Okay. The Commonwealth government has guaranteed that operational funding for the Palmerston hospital will be provided once it is complete. Can you outline any agreement between the Commonwealth and the Northern Territory government in relation to the operational funding of the Palmerston hospital? Has there been any discussion?

Prof. Halton: Where are you reading that from, Senator?

Senator PERIS: The member for Solomon in the Northern Territory has said, 'Once the Palmerston hospital has been built, there will be ongoing funding.' Have there been any discussions with the Commonwealth or the NT government?

Ms Anderson: I can only think that that would be in the context of the fact that the activity which is delivered through Palmerston hospital would attract a contribution from the Commonwealth, as for any other public hospital activity, through the activity-based funding formula.

Senator PERIS: All right. Just recently, the Chief Minister of the Northern Territory claimed that on 1 July the Northern Territory will lose $33.8 million, which represents 30 beds. Do you agree that the $33.8 million figure represents the annual operational funding for 30 hospital beds?

Prof. Halton: I go back to what we said to Senator McLucas, and I think we said it to Senator Di Natale: we cannot comment on a state-by-state figure because it is a question for the Treasury.

Senator PERIS: Okay.

Senator McLUCAS: Surely the health department understands the cost of operating a bed in the Northern Territory.

Prof. Halton: We will have to take it on notice.

Senator McLUCAS: But, just as a matter of principle, you would know that.

Ms Anderson: It is not that straightforward. The jurisdictions have not shared any of their modelling with us, except on a bilateral discussion basis. We have not had any conversations with the Northern Territory officials which would give us insights into the assumptions they have made in that modelling.

CHAIR: Senator Whish-Wilson has a very quick set of questions, I understand, and he is trying to work in several committees. If senators are happy with that, we will go to Senator Whish-Wilson for a very quick series of questions.

Senator WHISH-WILSON: Very quick, I promise. My question relates to the closure of transitional units for aged-care patients. Could you confirm that the transitional unit that was located at the Manor aged-care facility in Kings Meadow was closed under this—

CHAIR: Aged care is no longer within the Health portfolio. Are these questions that would apply here or not?

Prof. Halton: It depends on—

Senator WHISH-WILSON: It is a transitional arrangements for hospitals. That is the—

Prof. Halton: Except some of the transitional arrangements were actually funded by aged-care places, so I do not know that we can answer the particular questions.

Senator WHISH-WILSON: Could you confirm if it was cut under your budget?

Prof. Halton: If it was something we funded? I would have to take it on notice. But a lot of the transition stuff came out of places under the aged-care ratio, which is not our portfolio. Can you tell us what the detail is and we will have a look at it.

Senator WHISH-WILSON: Okay. It was the Manor aged-care facility in Kings Meadow, in Launceston. The unit was designed to take pressure off the Launceston General Hospital by taking elderly people who were healthy enough to leave the hospital.

Prof. Halton: Yes, I am aware of the circumstances. We will take it on notice.

CHAIR: So is that a Health question or an Ageing question?

Senator WHISH-WILSON: I think it is both.

Prof. Halton: I think it may be Ageing. I have actually been to that service, but I think it may have come out of the Ageing—

CHAIR: Could we confirm that for Senator Whish-Wilson before Ageing comes up on I think it is Wednesday?

Prof. Halton: Yes, we will certainly endeavour to do that.

Senator WHISH-WILSON: That would be fantastic. Thank you very much.

CHAIR: Senator Peris.

Senator PERIS: With regard to the Palmerston hospital, has there been any change to milestones?

Ms Anderson: Again, I apologise; I do not have that information, but we are happy to provide that to you on notice.

Senator PERIS: I just want to get my head around this. The Commonwealth funding in the budget papers was for $40 million over the next couple of years; there was nothing further committed after that?

Ms Anderson: The commitment stretches over three financial years. That is the $70 million plus the $40 million. The expenditure profile commences in 2014-15 and then runs through until the end of 2016-17.

Senator PERIS: Can you give the breakdown for each year up until then?

Ms Anderson: Yes, I can do that. It is separately cash-flowed, so I will give you—

Senator PERIS: What do you mean by 'cash-flowed'?

Ms Anderson: There are two different profiles. It is just an accounting ruse. The funding shall flow in a particular financial year and the $70 million is partitioned differently from the $40 million. But it is all money at the end of the day. In relation to the $70 million, the profile is expenditure of $35 million in 2014-15, $26 million in 2015-16 and $8 million dollars in 2016-17. I think $1 million has already been provided.

Senator PERIS: That is what you call the cash flow—that breakdown you have just given.

Ms Anderson: Yes. For the $40 million, it is over two years. There is payment of $20 million in 2014-15 and $20 million in 2015-16. Effectively, from the Northern Territory government's perspective, it will be funding of $26 million plus $20 million—$46 million—in 2014-15, subject to achievement of construction milestones as negotiated and agreed between the two governments.

Senator PERIS: That is what you cannot give me at the moment—the construction?

Ms Anderson: No, I am not aware of how advanced that negotiation is.

Senator PERIS: Am I able to obtain a breakdown of Commonwealth funding for hospitals in general across the Northern Territory over the last two financial years and over the two years in advance of the forward estimates?

Ms Anderson: Are we talking about capital funding?

Senator PERIS: Yes.

Ms Anderson: I will be happy to provide that for you.

Senator DI NATALE: I have a question about the long-term future of hospital funding. Is it fair to say that the role of efficient pricing in the future—that we have ditched that and are moving to block based funding? Is that the long-term trajectory here?

Prof. Halton: I think you have put together a couple of things that do not necessarily follow. As Ms Flanagan indicated earlier, there is going to be a conversation with the states and territories in a whole series of domains, one of which will be putting the efficient price function into this broader body. As has already been indicated—

Senator DI NATALE: What broader body?

Ms Flanagan: The Productivity and Performance Commission, which is going to merge a number of bodies together.

Prof. Halton: That is subject to discussion with the states.

Senator DI NATALE: This is cross-portfolio? I am not sure—does this relate simply to hospitals?

Prof. Halton: You may have missed the discussion earlier. The function continues. It is going to be, subject to discussion with the states, included with a series of other performance functions and so on in the one body. The point is that the function continues. We have to have a conversation with the states and territories. Payments for the next three years will be on this basis, as we discussed previously. We do not have crystal balls, so I cannot tell you where those discussions will end up. Is there a role for pricing in any management of the hospital system going forward? I would be very surprised if there were not. But how those mechanisms all work is a conversation we have to have with other parties.

Senator DI NATALE: That is effectively what I wanted to know—whether there has been any sort of discussion about moving away from that model altogether.

Prof. Halton: No, there has not been.

Senator DI NATALE: I will leave it there. I have a few other questions I will put on notice.

Senator SMITH: I would like to go back to the offer that the secretary gave us to enquire about using hip replacements as a way of trying to demonstrate cost variations. Could you step us through that, Mr Sherbon?

Dr Sherbon: I cannot do that in detail on hip replacements. But I can inform you that, in the most recent cost data available, the highest cost local hospital network in the country at the moment is 23 per cent above the average cost of hospitals in the country.

CHAIR: What is the cheapest one?

Dr Sherbon: My staff will get that figure while we are talking. There is a variation above and below the mean that is quite substantial, as you can see from that figure I just gave you.

Senator SMITH: You used the words 'local hospital network'. Is that interchangeable with the term 'public hospital', or are they different things?

Dr Sherbon: The local hospital network is the legal entity in each state or territory that groups hospitals together. The figure I gave you is for the highest cost local hospital network versus the average cost.

Senator SMITH: So we have got one at 23 per cent. Do we then have another one at 21 or 22, or is there a big—

Dr Sherbon: There is a distribution of costs above and below the mean.

Senator SMITH: What is the range?

Dr Sherbon: It ranges from 23 per cent above and I will get you the figure below.

Senator SMITH: Can you explain to those of us who are not hospital pricing experts what that actually means? Why is that important?

Dr Sherbon: As the secretary alluded to earlier, reduction of variation is a major opportunity for efficiency gains within the system.

Senator SMITH: When we say 'efficiency gains' we mean a more efficient use of public money.

Dr Sherbon: Indeed, for the desired outcomes. As the secretary mentioned, if a fairly standard procedure such as an uncomplicated hip replacement is performed in a hospital, there should be, theoretically, fairly standard costs. If there is substantial variation, that indicates that there are opportunities for efficiency, particularly when the costs are above the average costs. At the moment, my authority prices at the average cost, and that is our efficient price. But, as you can see, where there is variation above the average cost there is a major opportunity for efficiency gains across the country, and that is well underway as we speak.

Senator SMITH: Where we see costs that are above the average, do we see them clustered around certain jurisdictions, or are they evenly spread across jurisdictions?

Dr Sherbon: They are not evenly spread across jurisdictions. There are some jurisdictions that have a higher cost distribution than others. All jurisdictions have indicated to us they are working busily towards gaining efficiencies, and the jurisdictions can speak for themselves, as expressed in their budget papers. You will see in all the state budgets that are either published or about to be published that most states and territories are working towards the national efficient price if they are above the national efficient price. In answer to your previous question, the lowest cost hospitals are 27 per cent below the national average cost, which in turn is the national efficient price.

Senator SMITH: In layman's terms, those that are operating below the average are doing very well for their public hospitals. Not wanting to embarrass those that are not doing well, can we reward those that are doing well and those jurisdictions they might cluster around?

Dr Sherbon: As you have heard, under activity based funding, if a jurisdiction or a local hospital network is able to deliver hospital services below to the national efficient price, there is obviously a theoretical margin there between the national efficient price and their cost, and they can use that to invest in other health services if they wish. That is assuming that the state or territory does not use a different mechanism to fund aside from the national efficient price. Some states alter the national efficient price as it makes its way through. But, for the purposes of Commonwealth funding, the national efficient price determines Commonwealth funding to local hospital networks.

Senator SMITH: Can you talk to me about the success of the national elective surgery targets and the national emergency department targets under the national partnerships agreement?

Ms Anderson: These two targets were established in the course of the national health reform agreement negotiations, where there was a general agreement by first ministers that it was important to set targets for improving performance in emergency department waiting times and for people waiting for elective surgery. As I said earlier, targets were negotiated with each jurisdiction and they were stepped out to recognise that improvements would occur over a period of time—in fact, over a period of years.

Senator SMITH: So targets for each jurisdiction were different?

Ms Anderson: Yes.

Senator SMITH: Based on their own—

Ms Anderson: It was based on where they started. We had an assessment of how they were performing at the beginning of the period and then, at increments beyond that for successive improvements in performance. There was a certain amount of money which was given to states and territories which was for facilitation and for capital for both emergency department improvements and, also, elective surgery improvements. That was a fairly substantial amount of money. That has, already, all been paid. In addition, reward funding was made available which would kick in after the facilitation and capital payments had been exhausted, which was far more modest in scale and scope, which reflected that there may be some additional modest incentive available. It is fair to say that performance of states and territories against their agreed targets has been patchy at best.

Senator SMITH: So they all started from their own positions, so to speak, and Commonwealth money was provided to support them moving towards the agreed targets that the Commonwealth and the state, or the jurisdiction, met in cooperation. And the result of that has been, to use your word, 'patchy'?

Ms Anderson: That is correct. The Commonwealth has already paid $1.15 billion in additional funding to states and territories for improved performance in emergency department waiting times and elective surgery waiting times.

Senator SMITH: So the $1.15 is a cumulative figure for those two particular programs, I take it?

Ms Anderson: Yes, that is correct. In 2012 the only jurisdiction of eight to fully achieve its target for emergency department waiting times was Western Australia.

Senator SMITH: I did not know that, but that is pleasing to hear given my parochial approach. So it is $1.15 billion over how many years?

Ms Anderson: Since 2010.

Ms Flanagan: Ms Anderson is talking about one particular national partnership agreement. There have been previous agreements for elective surgery and a one-off payment for emergency departments that also occurred before 2010. This is from the most recent national partnership.

Senator SMITH: So it is $1.15 billion since 2010 to improve performance of national elective surgery targets and national emergency access targets. The success of that has been patchy. The only state to have met its targets is Western Australia?

Ms Anderson: Met its emergency access targets for 2012. In relation to elective surgery, it becomes a bit more complicated. There are a number of targets there. The clearest target is that people will be treated within their clinically recommended time, according to their urgency category. We have three categories of surgery—one, two and three. The first is within 30 days, the second is 90 days and then the third is 365 days. The target is that, ultimately, everyone who is recommended for surgery within 30, 90 or 365 days is in fact operated on within that period. Again, there are stepped-up targets for each jurisdiction, according to where they started and where we want it to end. In 2012 the only two jurisdictions to achieve that part of the elective-surgery target were ACT and Northern Territory.

Senator SMITH: In that $1.15 billion period, how many measurement points are there? Do they get measured twice a year? Does that make sense?

Ms Anderson: I think it is annually—certainly it is reported, publicly, annually.

Senator SMITH: We had a national partnership agreement where $1.15 billion was spent, in the period from 2010, to directly address elective-surgery targets and emergency-access targets and we have very poor performance. In very rare circumstances were those targets met, which the states themselves negotiated with the Commonwealth.

Ms Anderson: Unfortunately, we had some states going backwards.

Senator SMITH: Which states went backwards?

Ms Anderson: In relation to performance on emergency access in 2012, Victoria and New South Wales moved slightly backwards against their baseline target. It was a small amount, but it was lower than where they had started.

Senator SMITH: I would imagine that the targets were set to be achievable, not to disincentivise jurisdictions from trying to meet the targets.

Ms Anderson: The targets were agreed with each jurisdiction.

Senator SMITH: That is interesting; that is fascinating. It demonstrates the point that large sums of taxpayers' money might be spent in the health area, and it might look good in terms of what it represents on paper but it may not actually deliver on-the-ground outcomes for people who, in this case, needed timeliness around elective surgery or emergency access.

Ms Anderson: On the evidence, that would appear to be the case.

Senator SMITH: I turn briefly to South Australia who have had a bit to say—I have seen the media reports as well—about the Commonwealth's new approach. I am just curious to know how many hospitals in South Australia met their national emergency-access targets under that agreement.

Ms Anderson: According to the report that has been recently issued by the National Health Performance Authority—

Senator SMITH: And this is the time that patients spent in emergency departments in 2012-13.

Ms Anderson: That is it, yes. The majority of hospitals in South Australia did not meet their targets; in fact, in terms of 2012, we had one hospital out of five that met its target.

Senator SMITH: What is the figure for 2013?

Ms Anderson: It is zero hospitals out of five.

Senator SMITH: What was the South Australian target?

Ms Anderson: It was 75 per cent.

Senator SMITH: Going back to your earlier commentary about 30 days, 90 days and 365 days, does that 75 per cent relate to—

Ms Anderson: No. The three urgency categories are for elective surgery. These figures relate to access to emergency departments' services.

Senator SMITH: Of the five hospitals—I am assuming some are non-metropolitan located—do you have any commentary around that?

Ms Anderson: I believe Modbury might be the only one—

Senator SMITH: My line of questioning stops there, because they are not meeting the targets. Do you have any information about what they actually reached? We know they did not reach the target, but what was the percentage score?

Ms Anderson: Queen Elizabeth, for the period January to December 2012, achieved 62 per cent; Lyell McEwin achieved 50 per cent; Royal Adelaide achieved 51 per cent; Flinders achieved 51 per cent; and Modbury achieved 68 per cent.

Senator SMITH: That is way short of the 75 per cent target.

Ms Anderson: Yes.

Senator SMITH: In some cases, that is very, very far away from the 75 per cent target.

CHAIR: Last question, Senator Smith.

Senator SMITH: I was going to ask about the evolution of public hospital funding, from the Health Reform Act to the current national partnership arrangements, but time will not allow me.

CHAIR: We may have a chance to come back to that, Senator Smith. Senator Moore had a follow-up question on this.

Senator MOORE: Ms Anderson, the information you are reading from, which was on individual hospitals—is that available on hospitals across the country? We had a series of questions there on South Australia, but I would be really keen to have a look at the situation of hospitals across the whole country.

Ms Anderson: Yes. This is from a publication put out by the National Health Performance Authority in May.

Senator MOORE: That is what I thought.

Ms Anderson: I am happy to make that available.

Senator MOORE: That would be lovely. And that publication is available publicly?

Ms Anderson: Yes, it is.

Senator MOORE: If you can get me another one, I would very much like it. But I know it is there.

CHAIR: Senator Peris.

Senator PERIS: Before, when I asked if you were able to give me a breakdown of the Commonwealth's contribution to the NT, I asked for just capital, but if you are able to do capital with the health and hospital, and operational.

Ms Anderson: Yes, all right—happy to do that.

Senator MOORE: Okay—for 2012-13 and then what is committed over the forward estimates.

Ms Anderson: Yes, we will get the operational recurrent funding from the Administrator of the National Health Funding Pool.

Senator PERIS: Thank you.

CHAIR: Senator McLucas.

Senator McLUCAS: In the government's Budget 2014-15—Health publication, it states that the government is 'removing ineffective or wasteful funding arrangements' in the public hospitals. Could the department provide me with an understanding of what ineffective and wasteful practices under the public hospital funding arrangements are being referred to in that document?

Ms Flanagan: I think it goes back to the earlier discussion that we were having around the use of the national efficient price and the variation that Dr Sherbon described around the average price. The importance of this is that, from 2014-15 on, for some time, the Commonwealth government will contribute 45 per cent of growth—that is, all new services that are delivered—and we rely on the states and territories to tell us how many of those services are to be delivered. So it is basically: x multiplied by y gives you the result. Using the national efficient

price will, in effect, focus hospitals and local hospital networks on what are the cost drivers in their hospitals. That is certainly the intention.

Senator McLUCAS: But you have not actually identified any activities or things that they do that are inefficient or wasteful funding arrangements.

Ms Flanagan: Again, the states and territories run the hospitals, so we would be providing a price signal for them to examine that.

Senator DI NATALE: The inference is that one hospital does it cheaper than the next hospital. Are we controlling for other variables—rural versus urban, and so on? There will be different cost structures associated with the operation of those hospitals. Are we controlling for demographic factors? Obviously, hospitals servicing areas where there are higher groups of Indigenous communities or lower socioeconomic communities will have higher cost structures because of co-morbidities and so on. So, when you are comparing the price of doing a procedure in one hospital versus in another, are you controlling for those variables?

Ms Flanagan: Dr Sherbon might like to answer that.

Dr Sherbon: Yes, I can answer that. Yes is the answer. The national efficient price is a single figure but, within our activity count, the national weighted activity unit, we factor in factors such as indigeneity, remote residence and a whole range of other factors.

Senator DI NATALE: Are there other factors that you think might be excluded that could potentially account for that difference?

Dr Sherbon: There are some other factors, most of which go to efficiency, variation in practice, high wage costs, disposition of staff, disposition of service, design and length of stay. They are efficiency factors that hospitals can work on. The Grattan Institute published a paper two or three months ago under Professor Duckett's authorship, and he argued that there are other factors beyond those that IHPA controls. As I mentioned, IHPA controls for indigeneity, remote residence and a couple of other factors which largely relate to the clinical care of the patient. He argues that there are other factors in relation to patients that should be taken into account that we cannot measure yet.

Senator DI NATALE: Do you want to outline what some of those are?

Dr Sherbon: In particular he argues that there are things like the status of the patient on admission with respect to some of their pre-existing conditions and some other factors that I will have to detail for you perhaps in a subsequent answer on notice. He argues that those factors should be taken into account. We cannot measure them as yet but we have undertaken in our next pricing round, NEP 15, to explore them and test for them in the national hospital cost data collection.

Senator DI NATALE: Is it not exactly the point that you are making an assumption? I am sure that some of this does reflect variation within hospital practice, but the conclusion is if one hospital does something, does a hip, a bit cheaper than the next hospital, then that other hospital must be inefficient and you have not controlled for all the other factors that may in fact result in the difference in price. To draw that conclusion so emphatically, as you do—

Ms Flanagan: Senator, I did not draw that conclusion.

Dr Sherbon: Senator, it is the authority who draws that conclusion rather than the department. The authority is confident that it has control for as many patient based factors that it currently can.

Senator DI NATALE: But not all of them.

Dr Sherbon: Not all of them but all of the material ones. I think that there is an argument at the margin that we will explore in the coming year, but substantially the authority—which is not just me, it is an authority of eight members—considers that it is controlled appropriately.

Prof. Halton: And let us be clear; the department agrees with the authority on this and the reality is that the kinds of factors you are talking about do not explain 23 per cent in the example that was just given in respect of hip replacement.

Senator DI NATALE: It makes plain some of it.

Prof. Halton: It may explain a tiny proportion of it but I do not accept that it explains 23 per cent. I think the point that Dr Sherbon is making is an absolutely robust one—they have controlled for what they believe to be the major and material differences. We used to have this conversation about aged care, which is no longer my responsibility, all the time about exactly how much variability do you have to take account of. Let us be clear; in any one service they are going to see a variety of people and it is very hard to run an argument that says all of the

people in that service are going to have features that are so different. In any event there are ways of dealing with those kinds of outliers if you really have to. You can have a fine-grained academic argument about whether or not you have control—

Senator DI NATALE: I do not think it is fine-grained.

Prof. Halton: I think it is over these areas.

Senator DI NATALE: I do not think Professor Duckett's argument was what he would consider to be fine-grained or academic.

Prof. Halton: Well it certainly was academic.

Senator DI NATALE: I think he was putting forward a fairly substantive argument. The point is that the response has been, and we heard it in earlier evidence, 'we are going to cut your funding because you are inefficient and by providing this funding we are reducing the price signal to you that would drive efficiencies'. It is a much more complex picture than that.

Dr Sherbon: But hospital managers, of which I used to be one, do not just take one incentive and drive toward one incentive. As you are aware from having worked in the system, there are other incentives and other targets that managers are required to meet. The efficiency incentive and the efficiency target is one amongst many. There are others as the secretary and other have outlined—the National Health Performance Authority reports on quality; you have just discussed access outcomes. So the argument, at a hospital level, is not as simplistic as focusing on one table.

Senator DI NATALE: The reason we are having this discussion is that we want to know the rationale for reducing the funding going to hospitals, which is outside your area—I know you cannot speak about that, but that is the point. That is being used as the argument to say, 'Well, we are going to actually withdraw funding for some hospitals because of waste and inefficiency.'

Senator McLUCAS: Were you asked to do any modelling from the point of view of the Independent Hospital Pricing Authority around this notion of wasteful or ineffective funding arrangements? Were you asked to have a contribution to the discussion about cutting $1.8 billion out of our funding for health and hospitals?

Dr Sherbon: Not specifically—we are required under the National Health Reform Agreement to supply first ministers in all jurisdictions with a projected national efficient price, which is a confidential projection. But, no, we were not specifically given that task.

Senator McLUCAS: Most knowledge is held in your authority around what real prices are and what real waste and inefficiencies might be. It is unfortunate that you were not asked to make a contribution to these deliberations—but that is a comment, I think. I am going to move back to indexing. It was a decision of government to move to—and I do not agree with it—a 'fair' indexation rate, which is CPI and population growth. We index it in a number of ways between the Commonwealth and states at the moment, in health. Has the department done an analysis of what the change in indexation rate would mean in cash terms to states and territories—with the move away from the current indexation rates to CPI and population growth?

Mr Maskell-Knight: I think in 2017-18, it is the $1.2 billion that is published in the budget.

Senator McLUCAS: That is separate from $1.8 billion?

Mr Maskell-Knight: The $1.8 billion has got three years worth of savings from the guarantee, and then it has $1.163 billion in the 2016—

Senator McLUCAS: Okay—that is the indexation cut.

Mr Maskell-Knight: That is largely the indexation—there will be a small contribution from the guarantee, but it is largely the indexation change.

Senator McLUCAS: Have we disaggregated the states and territories?

Prof. Halton: That question will have to be referred to Treasury.

Senator McLUCAS: It troubles me that Treasury is making decisions about health funding, when this is the department that has all the knowledge and understanding.

Prof. Halton: There used to be arrangements put in place under the reform agreements.

Senator McLUCAS: But there must have been some advice given to Treasury from Health about what this will mean for—

Prof. Halton: This is the arrangement that was put in place under the previous government, where the Treasurer is responsible.

Senator McLUCAS: I understand it is the arrangement that is in place, but surely the department did some work to inform what these cuts will mean in terms of patients, beds, hip replacements and all that sort of work?

Prof. Halton: Certainly, we are in constant dialogue with Treasury about implications of things, but the numbers et cetera are not our responsibility.

Senator McLUCAS: Good. Now we are getting to the point. From the assessment of the Department of Health, what will be the implications of cuts of this magnitude to our public hospital system? Has any modelling been done on that? Bed closures? Hip replacements? What will change when you take this quantum of money out of our public hospital system?

Prof. Halton: You are now doing a hypothetical, and we cannot answer that question.

Senator McLUCAS: No, I am not asking a hypothetical question. I am asking if you have done modelling to ascertain what the impact of this will be. I know the states and territories run the hospitals, but you have a very high level of understanding of what happens in a hospital.

Prof. Halton: You have asked a particular question, and I will have to take that on notice.

Senator McLUCAS: I am not asking for the answer; I am asking if you have done the work.

Prof. Halton: Yes, and I do not know whether I can characterise the answer to that question without looking at the material.

Senator DI NATALE: You are not sure if you have done any modelling on the impact of the cuts on state hospitals?

Prof. Halton: There are several documents I have in mind. I will have to look at them to see exactly how you would characterise them. The question that has been asked is quite particular and I have to go and look at them so I can be sure that I am answering the question correctly.

Senator DI NATALE: As far as I understood the question from Senator McLucas, it was essentially: have you done any modelling on the impact of these cuts on the state hospital system? Is that a fair representation?

Senator McLUCAS: That is right.

Senator DI NATALE: Is it right to say that there will be $35 billion out of health over the next 10 years? That is the figure that I have seen quoted.

Prof. Halton: I think it is $55 billion out of the $80 billion, but do not take—

Senator DI NATALE: So we have a $55 billion cut. Surely, you must have done some modelling to work out what that is going to do to somebody who needs to have their hip done or have bypass surgery done. It just beggars belief that you would not have done any modelling on the impact on public hospitals.

Prof. Halton: There are a whole series of assumptions in this question about what level of funding the states will contribute over a series of periods. This does not occur for another three years. There is a whole conversation to be had—

Senator DI NATALE: But the question is about whether you have done any work to explore some of these questions and the impacts.

Prof. Halton: The question I was asked was: have we done any modelling. That is what I have to look at, to see exactly how you would characterise—

Senator DI NATALE: Is the word 'modelling' the issue here?

Prof. Halton: Partly, yes.

Senator DI NATALE: Has there been any work done to look at the impact on our public hospital system?

Prof. Halton: We have some consideration of what the impact on financing arrangements might be, but I will have to refresh my memory as to the precise nature, particularly in respect of the question. I need to at least look at the material—that is my point.

Senator DI NATALE: Perhaps I could put a question on notice. Has any work been done by the department to examine the impact of the withdrawal of $55 billion of Commonwealth funds on public hospitals? It is very general.

Prof. Halton: We certainly do not do work that goes out to 10 years.

Senator DI NATALE: Okay, over the forward estimates.

Prof. Halton: We are happy to take it on notice.

Senator DI NATALE: I would like to know whether any work has been done to examine the impact on emergency departments as a result of the co-pay. In other words, have you done any work looking at what the impact of a co-pay will be through people deciding not to see a GP but instead to visit their emergency department? For example, the South Australian health department have modelled the cost of that as several hundred million dollars, which would extrapolate nationally to a figure in the order of billions of dollars. Their assumption was that four per cent of people who would otherwise see a GP would go to an emergency department. So my question is: have you done any work to look at the impact of the co-pay on hospital emergency departments?

Ms Flanagan: The answer is no, but we have had recent studies. For example, there was discussion by CEOs and, I think, health ministers about the concerns that states and territories had on introducing the four-hour access target. The states were concerned about what would happen to GP attendances—that is, they would become what is described as a honey pot. Interestingly, I think a lot of the work showed that that did not occur. So it is very hard to predict—

Senator DI NATALE: Sorry, what work showed that?

Ms Flanagan: The work showed that, in fact, it was not a honey pot—

Senator DI NATALE: Based on what, sorry?

Prof. Halton: The number of attendances.

Senator DI NATALE: But you have not introduced a co-pay yet.

Ms Flanagan: This was a study that the states did. What I am saying is that we have looked at past evidence of what may occur with attendances if you introduce a change either in an emergency department or in the GP space. The latest and most recent example that we have had of that, which the states and territories have been observing over the last couple of years, was what was going to occur when, in effect, we made it theoretically easier for people to be seen in a timely way in emergency departments. States and territories were very worried that they would, in effect, attract an increase in GP attendances.

Senator DI NATALE: Hang on—that is a completely different scenario to putting a $7 co-payment in front of someone to see a GP. Are you saying that is your evidence?

Ms Flanagan: I am saying what we try to observe is if something changes in the system, what might the impact be?

Senator DI NATALE: But surely the nature of the changes are critical here, and I suspect most people would not even know the four-hour target existed to start with. Secondly, to suggest that a four-hour target in the emergency department is going to have the same effect as a $7 co-payment—

Ms Flanagan: I am not saying it had the same effect, I am saying that what we look at when we can is what occurs in changes to people's behaviour when something like that is introduced. You asked whether we had modelled what might occur with the introduction of a co-payment. We have not done that. I was referring to what we have observed in the past when we try and change incentives—change between the two.

Senator DI NATALE: I understand that but with due respect they seem to me almost irrelevant in terms of the effect they will have on behaviour. One is a co-payment in primary care, the other is a four-hour figure in accessing emergency departments.

Ms Flanagan: We are theoretically—

Senator DI NATALE: Very theoretically.

Ms Flanagan: Well, we are changing the balance of incentives.

Senator DI NATALE: Presumably the South Australian health department have based the four per cent figure they quoted on evidence. Is that something you have examined? Given that you have sought to look at what sort of changes might impact on access to emergency departments I am assuming you would have also looked at their work to see what they based that four per cent figure on.

Ms Flanagan: I do not think they have given it to us.

Senator DI NATALE: Have you requested that information?

Ms Flanagan: I am not aware of whether we have, but certainly we do not have access to either the piece of work or the assumptions that underpinned it.

Senator DI NATALE: Is that something you would have some interest in given the nature of the change?

Ms Flanagan: If they chose to give it to us we would certainly be pleased to look at it.

Senator DI NATALE: Well, we might put in some phone calls.

Senator SMITH: I am keen to understand how moving from the Health Reform Act to the Federal Financial Relations (Consequential Amendments and Transitional Provisions) Act, which dealt with national partnership agreements, changed the nature of how funding was provided from the commonwealth to states, and in particular what that did in regard to certainty or longevity around funding commitments? Does that make sense?

Mr Maskell-Knight: Not a whole lot, Senator.

Senator SMITH: At least you are honest. The Howard government had an approach, the previous government had an approach, and I am just keen to understand what the key differences were in those approaches.

Mr Maskell-Knight: Until 2009 there were bilateral agreements between the states and the Commonwealth about the Commonwealth contribution to hospital funding, and payments were made from the Department of Health to states in some cases—to state treasuries in some cases, to state health departments in some cases. After the Intergovernmental Agreement on Federal Financial Relations, that funding was turned into the National Healthcare Specific Purpose Payment and it is now paid by Treasury to state treasuries under the terms of schedule D of the intergovernmental agreement.

Senator SMITH: And from a state's perspective what were the major changes in that approach?

Mr Maskell-Knight: I am not a state public servant, Senator.

Senator SMITH: No but you are familiar with the nature of Commonwealth-state funding arrangements for health.

Mr Maskell-Knight: I am indeed, but I think you are asking me to speculate about how the states might think about something.

Senator SMITH: We were talking about some changes that have been legislated that are well and truly in the public domain—I am asking you to share with me what were the changes for the states as a result of those.

Mr Maskell-Knight: The change was that in every state the money went straight into the state treasury, so some states had prior arrangements where the state treasury essentially topped up the money that their health department got directly from the Commonwealth. All states then moved to a system where state health departments received their funding direct from the state treasury, regardless of whether it was originally Commonwealth funding or state.

Senator SMITH: I thought there was a change in the certainty around the funding in terms of the numbers of years that states got the funding committed for.

Mr Maskell-Knight: Are you talking about parameter variations?

Senator SMITH: Yes.

Mr Maskell-Knight: Under the pre-existing arrangements until 2008, there were parameters and there were adjustments to funding between the budget and the end of the year. Those arrangements were usually subsumed in the last payment of the year in June. Post-2008-09, those final adjustments have been made in the following financial year.

Senator SMITH: What influences the changes around those parameters?

Mr Maskell-Knight: Under the 2009 agreement, amounts are indexed in relation to population weighted hospital utilisation for movement in the five-year average total health price index calculated by the Institute of Health and Welfare and a flat 1.2 per cent technology factor. So while the budget in May is based on the latest estimates of those two things—given that the 1.2 per cent never changes—it is subject to variation at MYEFO and then again at the end of the year once the statistician produces final population estimates.

Senator SMITH: Is that growth calculation the domain of the Commonwealth or each state jurisdiction?

Mr Maskell-Knight: It is the Treasury.

Ms Flanagan: In terms of going into the future in terms of parameter variations, the states and territories are going to have a lot more influence in that, because they are going to predict what the activity levels are going to be across the year. The IPA will set the national efficient price, and then it will be multiplied by what the states and territories tell us what they want to do in terms of activity. Because we pay up front, it may mean that if the states come back and say, 'We have done a lower level of activity than we thought we had otherwise done,' we have to smooth that out in arrears.

Mr Maskell-Knight: Just to be clear, the model I was describing with population and health price index and technology factors ceases at the end of this financial year. From then on, as Ms Flanagan said, the only variable affecting within-year changes will be the amount of activity states do, as opposed to what they predict.

Senator SMITH: Staying with the activity that states will now be in a position to predict, how confident will states and territories be at predicting activity?

Ms Flanagan: They have been on training wheels for the last couple of years in the transition period in terms of trying to predict what their activity is. Some of them have a way to go in terms of working out how to predict activity. We have seen a deal of variation in terms of what is predicted and what activity is actually carried out by a number of the local hospital networks. Just as you would find with anything, some of them are pretty good at it, but there are others that perhaps need a little more work.

Senator SMITH: Can that be characterised as a feature that gives states more certainty in their ability to predict activity, but there is also a risk, because, if the activity that is predicted is not realised, that money will have to come back to the Commonwealth?

Ms Flanagan: The Commonwealth will have to recover it, yes.

Senator McLUCAS: I just want to ask some questions about the practicalities of asking state and territory governments to put a co-payment on presentation at emergency departments. I understand that the policy says 'For GP-type attendances'. Is that correct?

Ms Flanagan: That is correct.

Senator McLUCAS: So someone turns up at a hospital—what happens? How do we do this, how do we get that person to pay $5? It is $5, isn't it?

Ms Flanagan: No, it is a matter for the states. In terms of GP type attendances, there is already some work, I think, being done by the Australian Institute of Health and Welfare, to determine what a GP like attendance looks like. You would appreciate that, as happens at the moment, those judgements are made each and every day in an emergency department, where Mrs Kafoops will be offered advice, to say 'You can stay here; however, there is a GP clinic down the red line that you might like to go to.'

Senator McLUCAS: I will ask the question in a different way. Can you describe what a GP type attendance is?

Ms Flanagan: As I said, emergency departments make those decisions all the time. We are going to have a theoretical interpretation of what a GP like attendance is, as I understand, from work that is being done by the Australian Institute of Health and Welfare.

Senator McLUCAS: But there is a classification, is there not?

Ms Flanagan: I do not know that I would describe it as a classification.

Senator McLUCAS: Is it just non-admittance?

Ms Flanagan: Often, you can be sent home from hospital without necessarily going to a GP. For example, you are observed for an amount of time and your condition has stabilised. My daughter unfortunately has allergies, so she gets stabilised in hospital if she has an allergic reaction. She is not sent to a GP. She is not admitted. She actually goes home.

Senator McLUCAS: Someone turns up who has had an accident. They are not admitted; they have gravel rash. My understanding is that this would be a GP type attendance. They are admitted. They may have diagnostics done. But my understanding is that under the current classification it is a GP type attendance. Do you take the $7 or whatever amount of money when they turn up, and is that person better treated at an emergency department than at a GP's surgery?

Ms Flanagan: The decision here is that states can be permitted to charge a GP like attendance item, if they choose to do so. Some states and territories have already come out and said they are not intending to do that, but it is up to the states and territories to make those decisions. There is nothing reflected in the budget bottom line for whether they choose to do that or not.

Senator McLUCAS: The rationale for that is because the Commonwealth is concerned that putting a co-payment on GP attendances will push more people into the emergency departments of our hospitals. To stop that push into that part of the health system, the Commonwealth is encouraging states to put a price on attending ED for GP type attendances.

Prof. Halton: The states have not claimed that in the past. If the states have claimed that, therefore, if they believe that is a concern to them, they have the choice.

Senator McLUCAS: I am trying to understand the practicalities of how this will be implemented, because the classification system on GP type attendances, I understand, is non-admittance to the hospital.

Prof. Halton: No, I do not think that is correct. You will find it is more complex than that.

Senator McLUCAS: Who can explain that better to me then?

Prof. Halton: AIHW do have a classification. I do not know whether Professor Baggoley would like to contribute. For example, there are classifications that go to the immediacy of the issue that presents, which are also germane. You may not be admitted, even though you have a relatively immediate need to see a practitioner. I can think of—

Senator DI NATALE: Someone can come in with chest pain and it can be indigestion. Those sorts of practical questions, I am not sure how they work.

Prof. Halton: No—and, at the end of the day, this is a matter for the states and territories and we have not yet had a conversation with them about it, so I think you are asking us to speculate in an area where we actually cannot go any further than we have already gone.

CHAIR: One last question, Senator McLucas, and then we will break for lunch.

Senator McLUCAS: When was the last time a health minister was a permanent member of the ERC?

Prof. Halton: I am going to be wrong about this. We will take that on notice—but there has been.

Senator McLUCAS: Can we have the answer after lunch?

Prof. Halton: Not necessarily, Senator, because you are asking me to do research which is beyond my portfolio. In fact, I would be within my rights to suggest that that question be put to the portfolio that is responsible, and that is Prime Minister and Cabinet.

Senator McLUCAS: Thank you.

Senator MOORE: Chair, can we just follow up with Ms Anderson—

CHAIR: Is this just one question, Senator Moore?

Senator MOORE: It is just a follow-up about the questions that Senator Peris put on notice about the funding in the Northern Territory: when might we expect to get those answers back?

Ms Anderson: We will do it as quickly as we can.

Senator MOORE: Right. Before the end of tomorrow?

Mr Maskell-Knight: In relation to operational funding in relation to recurrent funding, the Administrator of the National Health Funding Pool publishes a report every month setting out how much Commonwealth funding has gone to the two local hospital networks.

Senator MOORE: Is that on a website?

Mr Maskell-Knight: Yes.

Senator MOORE: And what is the name of that website?

Mr Maskell-Knight: It is publichospitalfunding.gov.au.

Senator MOORE: We will look at that and get back to you on whether that answers our questions. But thank you very much; I did not know that one.

CHAIR: We will now suspend for lunch and come back on outcome 2—access to pharmaceutical services.

Proceedings suspended from 12:36 to 13:34

CHAIR: We will move on to outcome 2, pharmaceutical services.

Senator McLUCAS: Can I get an understanding of the basis for the amounts chosen for the increase in the co-payments on the PBS—the $5 for general patients and the 80c for concessional patients? What was the rationale behind those particular amounts?

Ms McNeill: Those numbers represent an increase of 13 per cent for both concessional patients and general patients.

Senator McLUCAS: Why was 13 per cent the magic number? What brought you to 13 per cent?

Prof. Halton: It was a decision of government.

Senator McLUCAS: Minister, what was the basis for 13 per cent being chosen as the amount of the increase?

Senator Nash: My understanding is that that was the decision taken as the figure to provide a sustainable way forward for the PBS.

Senator McLUCAS: Can you give me an understanding of how that works?

Senator Nash: No, but I can take that on notice for you.

Senator McLUCAS: So you do not know?

Senator Nash: No, but I can take that on notice for you.

Senator SIEWERT: Minister, I would have thought that would have been a question you would have realised we would like to know the answer to—on what basis that 13 per cent was established.

Senator Nash: I am sorry, but I am not privy to the thoughts in your minds about what questions you might like to ask. As I have indicated, I will take that on notice.

Senator SIEWERT: Could you take it on notice and get back to us over the course of this estimates, please?

Senator Nash: I can certainly attempt to do that for you.

Senator McLUCAS: What was unsustainable about the PBS, Minister?

Senator Nash: The growth. What we need to focus on is the fact that the health system overall was unsustainable. We were talking about the growth in health spending earlier. I think it was around 10 per cent, which is unsustainable. It is appropriate that government makes decisions that are sensible, that ensure we have a sustainable PBS into the future.

Senator McLUCAS: You are obviously aware that there are different views about whether or not the Australian health system is sustainable into the future and that your views are not shared by many in the community, including health economists who have done quite a significant amount of work on this. But now is not the time to have a conversation about that.

Senator Nash: Indeed, you are right. I do recognise that there are various views on this and that there have been over time. Your own previous Prime Minister, Bob Hawke—he and his then health minister, Brian Howe, introduced a co-payment. Their view, even back then, was that the health system was not sustainable. So there have been various views on this over time.

Senator McLUCAS: If we are going to go through the history, do not forget what happened next. Mr Hawke was not the Prime Minister for much longer after that.

Senator Nash: Indeed, but it was interesting.

Senator McLUCAS: The community do not like these co-payments. They did not then and they do not now.

Senator Nash: It is about making the appropriate decisions, as government, for a sustainable health system. That is what is appropriate and that is what the government has done.

Senator McLUCAS: Let us go back to the department, then. What modelling has been done in relation to the effects of the increased co-payment on access to medicines, medicine compliance and broader health services?

Ms McNeill: With respect to modelling, we do allow for the fact that when you put the general co-payment up by $5 there are a number of medicines on the PBS that are no longer subsidised by the government—the full cost is covered by the patient themselves. That was factored into the forward estimates.

Senator McLUCAS: That is only a certain portion of the array of drugs that are on the PBS.

Ms McNeill: Certainly. At the moment approximately 40 per cent of medicines are under the general co-payment. With the addition of the $5 to come into effect on 1 January 2015, combined with the impacts of price disclosure, we expect that to be up to 55 per cent. To give you context, in 2012-13, of the top 50 drugs by volume on the PBS, 34 of those were already under the general co-payment.

Senator McLUCAS: Have you done any work on what will change the community's access to medicine that will drive some of that reduction in expenditure?

Ms McNeill: Only with respect to the value of medicines under the general co-payment.

Senator McLUCAS: So you have done no modelling about changed behaviour of patients?

Ms McNeill: No.

Senator McLUCAS: Has anybody?

Ms McNeill: Not that I am aware of.

Senator McLUCAS: So we do not know what is going to happen.

Ms McNeill: We have seen changes to co-payments for a number of years, and we can see what the statistics are on the script volumes. But with respect to this particular measure: no. Only with respect to the general patients and those drugs going under the co-payment.

Senator McLUCAS: Has any work being done on compliance? With an increased co-payment, what sort of behaviour of patients happens in terms of compliance with the prescribed medicines?

Ms McNeill: With what we expect to happen as a result of the introduction of this co-payment: no.

Senator McLUCAS: No modelling has been done on the population groups most likely to be affected by the increased co-payment?

Ms McNeill: Who do you define as the population most likely to be affected?

Senator McLUCAS: The poorest and the sickest.

Ms McNeill: Those that receive a concessional benefit?

Senator McLUCAS: The poorest and the sickest—they are also getting an increased co-payment as well.

Senator Nash: Perhaps I can just assist the committee. I think, on average, that is deemed to be about $13.60 per year.

Ms McNeill: That is what I was going to say. If you are talking about the average number of scripts that those people use, then the average impact is $13.60 because we expect them, on average, to use 17 scripts a year. Of course, those patients that are high-volume users will continue to be protected by the safety net.

Senator McLUCAS: We will get to the safety net shortly. Is the department aware of any evidence that suggests that people will not fill or they will ration their prescriptions if they cannot afford them?

Ms McNeill: With respect to this measure: no.

Senator McLUCAS: Let's go to the current price disclosure measures. What savings are they having to the PBS?

Ms McNeill: If I go back to the 2007 reforms, which include all subsequent variations of price disclosure thereafter, we expect it to be $8.8 billion over that period of time. So that is going from 2007 out until the current outlook of the forward estimates in 2017-18.

Senator McLUCAS: Will all the savings from those measures that will have been in place by then for 10 years be used to support new drugs being listed on the PBS? What happens to that money? It has obviously been saved. What happens to it now?

Ms McNeill: I think that both under the previous government and under this government we have seen that all recommendations from the PBAC in recent years have been given full effect.

Senator McLUCAS: I am not sure that is the question I asked.

Ms McNeill: So we continue to list medicines on the PBS.

Senator McLUCAS: Does that $8.8 billion of savings stay within the PBS?

Ms McNeill: It is a matter for government as to how the medicines are funded.

Senator McLUCAS: So we cannot be assured that those savings stay within pharmaceuticals.

Ms McNeill: That is a matter for government.

Senator McLUCAS: With the design of reducing costs on the PBS, were there any other options considered in order to find so-called savings in the PBS?

Ms McNeill: That is a matter for government.

Senator McLUCAS: Minister, in the consideration of trying to find savings in the PBS, were options considered other than increasing the co-payment?

Senator Nash: I am not privy to that. I would have to take that on notice.

Senator McLUCAS: You would be aware that the Pharmacy Guild is quite concerned about the effect the increased PBS co-payment will have on patients.

Senator Nash: I know there have been some concerns voiced. I think we need to be very mindful of the fact that, over the last 10 years, the cost of the PBS has risen 80 per cent. Now, we need to ensure that we have a sustainable system that will allow for new and innovative medicines to be listed, and government is very mindful of that.

Senator McLUCAS: Does the government expect there to be a reduction in scripts being filled as a result of the increased co-payment?

Senator Nash: As I indicated earlier, the average cost to patients that are concessional, I understand, is around $13.60 a year. We would not expect, as I understand it, that to have a significant impact. But I will take that on notice to see if there is anything further I can add.

Senator McLUCAS: You would be aware that the Pharmacy Guild has said:

Policy makers should be aware that increasing the cost of medicines to patients can impact the utilisation of medicines, particularly among vulnerable groups.

That seems to indicate that the Pharmacy Guild thinks that there will be a reduction in scripts being filled.

Senator Nash: Well, they have expressed that view. Certainly, from the government's perspective, our intention is very much to ensure that the system is sustainable and we have taken decisions accordingly.

Senator McLUCAS: So it does not matter if people get sicker or do not take their tablets?

Senator Nash: I would not verbal me or—

Senator McLUCAS: As long as the health system is sustainable, that is okay?

Senator Nash: put words in my mouth, Senator. You know I did not just say that.

Senator McLUCAS: And you are going to get back to me on whether the government looked for any other measures that will keep the PBS 'sustainable'?

Senator Nash: I have undertaken to take that on notice for you.

Senator McLUCAS: I go now to the changes to the safety net. Just for the record, I wonder, Ms McNeill, if you could go through what the elements of the PBS safety net are so that we are all across those measures.

Ms McNeill: Certainly. For concessional patients, the current safety net is set at the equivalent of 60 PBS scripts per year at the concessional rate; and, for a general patient, it is set at a fixed dollar value. So, if I look to what the changes will be in January 2015, the general safety net will increase by approximately $145.30, from $1,452.50 to $1,597.80; and the concessional safety net will go from 60 scripts to 62. In 2016, we expect that the general safety net will then be increased to $1,798; in 2017, we expect it to be at $2,029.20; and, in 2018, we expect it to be at $2,287.90. For the concessional safety net, it will go up to 64 scripts in 2016, 66 scripts in 2017 and 68 scripts in 2018. I would like to just put one caveat on all of that, which is that the calculation of the safety net is reliant on the CPI figure for the September quarter on a 12-month average, and therefore these are very much approximates because they are completely dependent on what the final CPI figure would be in each year.

Senator McLUCAS: So there is a CPI increase and then 10 per cent on top of that; is that how it works?

Ms McNeill: That is correct.

Senator McLUCAS: So it could be six per cent more, really.

Ms McNeill: The Treasury papers, Budget Paper No. 1, do note that they expect CPI over the longer term to be 2.25 to 2.5 per cent.

Senator McLUCAS: Sorry; what am I saying? Yes. Thank you. So those figures you have given me are just the 10 per cent raw figures—

Ms McNeill: It is the 10 per cent plus CPI. It is fully inclusive, but with that caveat.

Senator McLUCAS: All right. Let us go to general patient use of the PBS. What is the average general patient use of the PBS? How many people get to the safety net now?

Ms McNeill: Going on a calendar year basis, in 2013 the number of cards issued for a safety net for general patients, noting that this can be for an individual, a couple or a family, was 119,463. That covered 236,942 patients.

Senator McLUCAS: When it goes to $1,452-plus—what is the safety net going to be in the first year of operation? It is the one figure that I did not write down, I am afraid.

Ms McNeill: It is expected to be $1,597.80.

Senator McLUCAS: Have you done any modelling on how many people would have hit that figure? Do you know how many people would have hit that figure, based on the current usage?

Ms McNeill: No, I would have to take that on notice.

Senator McLUCAS: You can do that?

Ms McNeill: I can take it on notice. I do not have it with me.

Senator McLUCAS: But it is a calculation that you can do? That is the question that I am asking.

Ms McNeill: Based on current script volumes, yes. It does vary slightly with the general patients because we do have to allow for changes that may occur because of price disclosure. We do not know what those final figures will be until the calculations are actually done. For example, the 1 October figures that will be coming through that will change the price of some medicines, could—depending what the price of those medicines are and depending on the volume they do—affect the safety net arrangements. For example, if it is a very high-volume drug, like a superstatin, it can markedly change what that estimate would be.

Senator McLUCAS: You said that there were 236,000 people accessing the general safety net. What proportion of people who use Pharmaceutical Benefits Scheme—i.e. Australians—is that?

Ms McNeill: It is a small component. There are about 16.3 million general patients.

Senator McLUCAS: We can do the calculation from there.

Ms McNeill: It is about two per cent.

Senator McLUCAS: You were going to work out how many people would have hit $1,597. Could you also do it for the other three years as well? What proportion of the current population will hit $2,287 by 2017-18. It is the same thing across the four years.

Ms McNeill: As I said, we would have to heavily caveat any estimates due to what I mentioned about price disclosure.

Senator McLUCAS: The $5 co-payment is not included in the safety net, is that correct?

Ms McNeill: Yes, it is.

Senator McLUCAS: It will be included?

Ms McNeill: Yes. Whatever price you pay, up to the maximum of the general co-payment amount, excluding brand premiums, is counted towards your safety net tally.

Senator McLUCAS: Has the department done any research or modelling on the impact of the increased safety net on pharmacists?

Ms McNeill: No.

Senator McLUCAS: All the other questions go to modelling. It is a bit troubling that not a lot of work has been done that will tell us what might happen with the public—in terms of access to and compliance with their medication regime.

Senator CAROL BROWN: Given the answers to Senator McLucas's questions about modelling, and there has not been any modelling done in terms of the impacts, what advice did the department give the minister in terms of the decision about these taxes?

Prof. Halton: I think we have a problem here with the word 'modelling'. The impact on pharmacy in terms of volume et cetera is something that is known, and advice is provided about those matters.

Senator CAROL BROWN: So, in terms of the question Senator McLucas asked about the impacts on patients of the pharmaceutical benefits co-payment, you said there was no modelling, Ms McNeill?

Ms McNeill: I said we had done the work with respect to the general co-payment and the impact that that would have there.

Senator CAROL BROWN: So did you provide any other advice to the minister about the impacts? Were you asked to provide any advice?

Ms McNeill: As the secretary has just referenced, with respect to modelling of the impact on pharmacy, no, we did not specifically model it, but we did look at the volumes and how that might change with respect to the movement of medicines from general.

Senator CAROL BROWN: Setting aside the word 'modelling', were you asked for any advice on these initiatives?

Prof. Halton: There were a range of matters of fact and information provided to the government about these measures.

Senator CAROL BROWN: Did the minister ask for advice on these initiatives?

Prof. Halton: There was advice sought and advice provided.

Senator CAROL BROWN: On what date was the advice sought?

Prof. Halton: We would have to take all of that on notice.

Senator CAROL BROWN: Also, the date on which it was provided?

Prof. Halton: We may not be able to tell you the date on which it was sought, but we will see what we can provide.

Senator McLUCAS: Ms McNeill, you said you have done some work on predicted change volumes. What sort of work is that? You are not predicting patient behaviour with that work?

Ms McNeill: No, we are purely looking at the factual basis of the dollar value of the medicine. So, as I said before, there are 34 medicines in the top 50 of volume that are already below the general co-payment. So when

you put the co-payment up by $5, suddenly all medicines that are below the 40-70 now become drugs that will not be subsidised by the government. They are likely to be fully met by the patient. They are also, therefore, able to be discounted by the pharmacies, so that is what we look at. That will change the cost of the medicine to the Commonwealth.

Senator McLUCAS: What is the predicted reduction in cost to the Commonwealth of that component? It is probably the only component you can absolutely quantify.

Ms McNeill: We do not just look at that. Obviously, if you put up the price of the co-payment for the concessional patient, you also look at how that reduces the cost of the medicine to the Commonwealth. So all medicines on the PBS, if they are provided to a concessional patient, attract some level of subsidy by the Commonwealth. There is no medicine that a concessional patient purchases that is less than the co-pay amount. That is also factored in, and that is where the $1.3 billion saving comes from.

Senator McLUCAS: I understand why the Pharmacy Guild is a little troubled!

Senator Nash: Perhaps I could add something which may assist. In terms of the sustainability, even at the March meeting of PBAC, there were $550 million worth of new listings recommended. We have a range of drugs currently being utilised. For melanoma, it is around $110,000 a year. So I think we just need to keep in mind also the significant costs to government—that is, the taxpayer—of delivering this, and we need to do it in the most efficient manner we can.

Senator McLUCAS: All of those drugs are helping people to have productive and healthy lives, to contribute to society, to pay taxes and to do all those things.

Senator Nash: I do not disagree at all. I am the daughter of a GP. I lived with this for many, many years. I understand exactly what you are saying. I am simply making the point that even now, with the $550 million in recommendations from PBAC in front of us, it is a significant financial impost to government—to the taxpayer.

Senator CAROL BROWN: But how can you say that when these measures have not been modelled? It does not seem that there has been much advice sought by the government or much advice given by the departments. And you are constantly talking about the sustainability of the health system, but you do not seem to have asked for any modelling.

Senator Nash: I would say that the government has deemed that these are appropriate measures to be taken. I think in the view of many it is a modest requirement in terms of the 80c and the $5 co-payment required under the PBS to ensure that we do have that sustainable health system into the future.

Senator CAROL BROWN: You should go out and talk to some pensioners.

Senator McLUCAS: Can I clarify where the savings from the increased co-payment are going? Are they staying within the PBS? Or are they going to the medical research fund?

Prof. Halton: All published savings, other than those in the discussion we had earlier about parameter variations, which are not savings, apply to this. All that discussion earlier about the capital fund applies to this.

Senator McLUCAS: So, they will go to the medical research fund?

Prof. Halton: Yes.

Senator McLUCAS: That is $1.3 billion out of pharmaceuticals. Am I right there?

Prof. Halton: Yes.

Senator SIEWERT: We have already established that there seems to be little modelling, but has there been any work done on the impact on the Aboriginal and Torres Strait Islander community?

Ms McNeill: The Aboriginal and Torres Strait Islander community continues to be subsidised under the Closing the Gap arrangement. Therefore, general patients receive their medicines at the concessional rate and concessional patients receive their medicines for free.

Senator SIEWERT: So they are not going to have to pay any of the—

Ms McNeill: They will pay the 80c. So, a general patient who is currently paying what was expected to be $6.10 would pay the $6.90.

Senator SIEWERT: Has there been any work done on the impact of that increase on Aboriginal and Torres Strait Islander peoples?

Ms McNeill: No.

Senator SIEWERT: Do you expect that there will be any? Has any thought been given to any impact there?

Ms McNeill: It is a matter for government whether they would like us to do that. We have been in discussions with various Indigenous representatives following the debriefs on the budget processes. Once those people were aware that there was only the 80c component there were not a lot of concerns expressed about how that might change. But obviously when we consult with stakeholders if there are concerns raised we will give that feedback to government.

Senator SIEWERT: It is unlikely to change the government's mind, though, isn't it, once this measure has already been brought into being?

Ms McNeill: That is a matter for the government, not for me.

Senator SIEWERT: Minister, have you given any thought to the impact that even the increase in the concessional rate will have on Aboriginal and Torres Strait Islander peoples?

Senator Nash: I can certainly take that on notice, if there was consideration in the determination of this.

Senator SIEWERT: But you are unaware of any consideration given to that at this stage?

Senator Nash: I am not privy to that consideration, but I can take it on notice.

Senator SIEWERT: That would be appreciated.

Ms McNeill: I probably should just put on the record that the majority of patients who access medicines under Closing the Gap do continue to get their medicines for free. That is the vast majority of patients who use the Closing the Gap measure.

Senator CAROL BROWN: Was the PBS co-payment a recommendation of the Department of Health or the Department of Finance?

Prof. Halton: We do not go into who said what; we simply—

Senator CAROL BROWN: Well, was it a recommendation of the Department of Health?

Prof. Halton: We are not at liberty to answer any of those kinds of questions.

Senator DI NATALE: I understand that some of my questions may have already been asked. They are really about any modelling that has been done on the impact of the increased co-payment. Has any work been done?—let us not use the word 'modelling'.

Prof. Halton: We have actually already answered all those questions.

Senator DI NATALE: And what was the answer?

Ms McNeill: We have modelled the impact on the general patients when medicines will move from currently being partially subsidised by government to being fully met by the patient because of the increase from $37.70 to $42.70 because we were talking about the fact that 40 per cent of medicines are currently below the general co-payment amount on the PBS and in combination with this $5 increase and price disclosure we expected that to rise up to about 55 per cent of those medicines, and that was modelled.

Senator DI NATALE: Sorry, that is not my question; my question is on patient compliance—the impact of the increased co-payment, and I will use more of a lay definition—on people actually taking their medicines and filling their script. Do you have any work that has been done to look at the impact of the increased co-payment on the proportion of people now compared with under the previous co-payment who will no longer fill their script?

Ms McNeill: With respect to this measure, no.

Senator DI NATALE: Has any work been done on that specific issue by the department previously—that is, to look at the impact of the co-payment on patient compliance?

Ms McNeill: We have looked at the patient co-payment from 2005, yes.

Senator DI NATALE: And what was the outcome of that work?

Ms McNeill: In 2005 the PBS general and concessional co-payments had a one-off increase of 20.7 per cent, or $4.90, and 21.1 per cent, or 80c, respectively. Immediately after the increases the general PBS volume decreased by 5.5 per cent, and a large component of that related to the fact that prices went below the co-payment, and the concessional volume decreased by 0.3 per cent. Overall, there was a drop in total PBS script volume combining general and concessionals of 1.15 per cent in 2006 and by one per cent in 2007 before they returned to their 2005 script volumes by 2008.

Senator DI NATALE: So, just to unpack that: we saw two things happening. One thing was that because of the impact of the co-pay on some medicines not actually falling under the PBS anymore—they are no longer subsidised—we saw a drop-off. But we also saw a drop-off in those medicines that are PBS subsidised.

Ms McNeill: For the concessions, yes—0.3 per cent.

Senator DI NATALE: On that basis, the immediate impact would be one in 300 people who did not fill a script because of the change in the co-payment. Is that correct?

Ms McNeill: No, it is about the number of scripts that were actually filled. I cannot break down as to whether it was an individual patient or whether a patient chose not to get a PPI versus something else.

Senator DI NATALE: Fair point; I get that. But the point is that there were fewer scripts filled as a direct consequence of the increased co-payment.

Ms McNeill: There were fewer scripts filled.

Senator DI NATALE: So why do you believe that things will be any different? In fact, some people might argue that things will be even worse under this increased co-payment. In other words, we could anticipate that as a result of the increased co-payment we will see fewer people filling their scripts directly because of the co-payment.

Ms McNeill: I have also seen in the data at the same point in time in individual drug categories that the drug script volumes have increased as well. So, if you are asking me to work out where someone will or will not fill a script it is not something I can comment on.

Senator DI NATALE: I am not asking you to do that. But we know in total that there will be fewer scripts filled as a result of this co-payment, based on previous evidence.

Prof. Halton: And we may also see things like substitution. I think that is the point the officer is making. You know well from your professional background that sometimes people substitute one for the other. In this particular case there is a 0.3 per cent reduction in overall script numbers but an increase in some other categories. We cannot disentangle what was the substitution of one drug for two, or any of those other issues.

Senator DI NATALE: But these are scripts written by a doctor—

CHAIR: One hopes!

Senator DI NATALE: one would hope—who has written a script because they believe a patient needs to take a particular medicine. And there has been a decrease in the number of scripts filled and therefore a decrease in the number of people complying with instructions from their medical practitioner to take a particular medicine.

Ms McNeill: But we do not know whether it will therefore change behaviour. For example, does someone move to a fixed dose combination? Or does someone who was previously getting paracetamol on the PBS—I have several versions of it on the PBS that are in the top-50 usage—suddenly go and get it over the counter instead?

Senator DI NATALE: You do not know that that is not somebody who has serious heart disease who decides not to take their blood pressure medication.

Ms McNeill: I do not know that either.

Senator DI NATALE: No, that is right; you do not.

Ms McNeill: That is what I am saying: I cannot comment on what you are suggesting, and neither can you comment on what I am suggesting.

Senator DI NATALE: I am just trying to establish the facts here, and the facts are that we had fewer scripts filled as a result of the co-payment.

Prof. Halton: That is an objective fact. And that was a 22 per cent increase as opposed to the 13 per cent increase we have seen this time.

Senator DI NATALE: The point is: fewer scripts filled as a result of the co-payment. One would argue that the best person to make the assessment about what should and should not be on a script is not the Department of Health, with due respect; it is the medical practitioner who is issuing the script. Therefore, does it not raise concerns for you that people are potentially going to be deterred from filling a script that may be absolutely critical to their health—a blood pressure medication, a diabetes medication—particularly for something for which they may not be experiencing symptoms but requires the medication to reduce their risk of things like heart attack and stroke?

Prof. Halton: You are asking us for an opinion, and you know we are not going to give you that.

Senator DI NATALE: In terms of doing that work around the fact that there were fewer scripts filled in 2005, was any further work done—and if not why not?—around the nature of the drugs for which people decided not to get their scripts filled?

Prof. Halton: You cannot take the number of scripts and then immediately equate that to a decision not to fill a script. We do not have information about scripts issued and not filled from that period.

Senator DI NATALE: You are saying there was a decrease?

Prof. Halton: Correct.

Senator DI NATALE: I just want to tease this out. There was a decrease in the number of scripts filled. Couldn't you compare it with pre-co-payment and establish where the reduction occurred? What is the data limitation there?

Prof. Halton: You are assuming that you can deduce—and we see shifts in volumes across different categories in the PBS in any event. So, we have no capacity to work out the cause of shift in volume.

Senator DI NATALE: You have just said—

CHAIR: Thank you, Senator Di Natale; that was your last question.

Senator DI NATALE: Well, that answer is not appropriate.

CHAIR: Perhaps I could just follow up on that. I know the pharmacy guild has statistics on how many scripts overall are not filled. Do you have those details?

Ms McNeill: No.

Prof. Halton: No.

Senator McLUCAS: I want to follow on from Senator Di Natale's comment. He was referring to data from 2005. The events that we are about to face are different in that not only is there an increased co-payment of 13 percent but also we have an increase in the co-payment around diagnostics and going to a GP. So, if we saw a reduction in volume in 2005 because of an increase in one co-payment—that is, the PBS co-payment—then surely we would expect that to be able to measure a reduction in volume of prescriptions filled followed three types of co-payments being introduced to the health system. I do not know whether you have done any work on that.

Prof. Halton: The estimates in terms of the expected impact, the reduction in volume, is as you see it in the estimates.

Senator McLUCAS: Just around the use of pharmaceuticals?

Prof. Halton: Yes, but the total effect is actually in the estimates.

Senator McLUCAS: And what do the estimates say about the reduction in volume in the figures in the budget?

Prof. Halton: You are asking for—

Senator McLUCAS: What are we expecting, from the figures that we have in the budget, will be the volume in the 2014-15, 2015-16 and 2016-17 years? What is the predicted reduction in volume in the work you have done to pull this budget together?

Ms McNeill: For subsidised scripts, we expect that in 2014-15 there will be 213 million. It will then be 227 million in 2015-16, there will be 242 million in 2016-17 and there will be 256 million in 2017-18. So we are still expecting the numbers to grow but by not as much.

Senator McLUCAS: And after 2014-15, the 213 million to 227 million, what was the component of the reduction out of that total amount? If that makes any sense at all.

Ms McNeill: I am really struggling with that one, sorry!

Senator McLUCAS: Okay. You can predict that this is the way that scripts will be filled in Australia, along this trajectory. But I think you are saying you have included a slight reduction in the total volume of scripts. What proportion did you model into that of reduction in volume that is attributable to the increased co-payment?

Ms McNeill: What we did there was we modelled the additional number that we thought would were in the non-subsided space for the general patients, and that was about five million.

Senator McLUCAS: Five million scripts that will move into the unsubsidised—

Ms McNeill: Unsubsidised, and then that compounds out over years.

Senator McLUCAS: But you are not factoring into that assessment any reduction in the use of pharmaceuticals?

Ms McNeill: No.

Senator McLUCAS: Why didn't you do that? You have the 2005 data that says, 'We expect there will be a dip and then it will track back up perhaps.' But why wasn't that figured into these numbers?

Prof. Halton: I think what the officer has is expected script volume. So we will have to come back on notice with the other data.

Senator McLUCAS: Do you understand what I am trying to get at?

Prof. Halton: I think so.

Senator McLUCAS: I suppose the question is: did you put into this number, 213 million scripts, an accommodation that you know there will be a reduction in volume attributed—

Ms McNeill: Attributed to not filling a script, as opposed to a script—

Senator McLUCAS: That is correct.

Ms McNeill: and the answer to that is no.

Senator McLUCAS: You did not do that?

Ms McNeill: No.

Senator McLUCAS: But, from the discussion you had with Senator Di Natale, you would be able to expect that there would be a change in patient behaviour?

Ms McNeill: We could see that after the fact. There are many factors that change script volumes. There have been changes to co-payments in the past, and those have had changes; and, if I have compared the way things happen at each particular point in time, it does not give a realistic expectation of what is actually on there at the moment.

Senator McLUCAS: Okay. I do not think you need to take that on notice. I think you have answered the question. Can I go to the abolition of the pricing authority and the PBS savings. Currently PBAC goes through an assessment of the suitability of a drug coming on the PBS and, up until 1 April, we had a second step, which was the Pharmaceutical Benefits Pricing Authority, which was the entity that negotiated a price between a proponent and the government. When was the decision made to abolish the pricing authority?

Ms McNeill: The decision was announced on 7 March 2014.

Senator McLUCAS: And what was the basis for that decision? Why was the pricing authority abolished?

Ms McNeill: By removing the Pharmaceutical Benefits Pricing Authority from the process, we are able to list medicines up to four weeks faster than was previously the arrangement. We were doing all the work already between the department and the pharmaceutical company in preparation for the recommendation of PBAC, when PBAC recommends that all the risk sharing and negotiations are undertaken between the sponsoring company and the department. We were then holding off to go to the PBPA. Given that PBPA is giving effect exactly to what PBAC had recommended, the government made the decision to expedite the listing process by four weeks and to remove that process. All processes that lead up to that still continue. The negotiations, the risk shares, the applications for price increases: all of that work and paperwork continues; we are just able to expedite it four weeks faster now.

Senator McLUCAS: That is the evidence that we have to that point?

Ms McNeill: Yes.

Senator McLUCAS: What pharmaceuticals can you point to that have been listed four weeks faster?

Ms McNeill: We have only just finished the March PBAC and we are in that process now. I look forward to giving you that answer at the next estimates.

Senator McLUCAS: I may have some questions on notice on the pricing authority. I just quickly want to go to the review of the Life Saving Drugs Program. What process will the review follow?

Ms McNeill: The Life Saving Drugs Program review will follow the post-market review processes outlined on the department's website. We have published the final terms of reference, having consulted on the draft terms of reference; we are currently doing some research with some academic institutions to prepare the material that then will be put before the reference group; and we will then be going out for public consultation on those papers.

Senator McLUCAS: And has the reference group been agreed?

Ms McNeill: It has not been finalised as yet.

Senator McLUCAS: What types of expertise would you require to be on the reference group at this point in time?

Ms McNeill: Andrew Wilson is heading the review and that has been publicly announced. We have representatives from the various specialty areas looking for specific clinical input; we have representatives from the disease advisory areas, such as Rare Voices, who have been publicly announced as being part of that reference group; and we will also have an ethics advisor in that space as well, but the final make-up is still to be announced.

Senator McLUCAS: Why was the decision taken to abolish the diseases advisory group?

Ms McNeill: The decision was taken to allow a very small number of clinicians, who are the experts in this field, to freely advocate and work with us on the Life Saving Drugs Program review—to be able to advocate for their patients. What we have put in place instead is the process that all other doctors in the country who prescribe complex medicines go through, which is the complex authority required process—which involves sending written forms into the department to continue the access for their patients. We have actually taken the opportunity to deregulate and streamline that process for those clinicians. They only have to put in their applications and their assessment data once a year to maintain access for their patients and they are free to apply for any new patients at any time. It is similar to the process that a medical oncologist would go through, or a rheumatologist—anyone who has to work in the treatment of very complex children. We still retain the access to medical practitioners where we may need advice and we know that the medical practitioners themselves tend to work in a community of specialists as well—to help each other in that space.

Senator XENOPHON: Let us go to the issue of the stalemate between the government and the manufacture of the cystic fibrosis drug, Kalydeco. I will truncate these questions given the time constraints. I am asking these questions on behalf of my constituent Leah Johnston's eight-year-old son who, along with 199 other Australians with cystic fibrosis, is in desperate need of this drug. My understanding is that the PBAC provided a recommendation to reimburse Kalydeco through the PBS and that that was in late 2013. Is that correct?

Ms McNeill: That is correct. They first recommended it in November 2013. The company put a subsequent application in to the March 2014 meeting and that was again recommended.

Senator XENOPHON: I have written to the minister about this, but where are we at in terms of Kalydeco being allowed through the PBS onto the market for these 199 Australians who are in desperate need of this drug?

Ms McNeill: The department is working quite furiously on this particular matter. We appreciate your concerns and we are working constructively with the pharmaceutical company in this regard. We met with them last week and we are meeting with them again this week. We have been exchanging information to progress this as quickly as possible since the recommendation in March.

Senator XENOPHON: What is the time frame? There are some very desperate parents worried about their children. Every day counts. How quickly can this be approved, in your view?

Ms McNeill: I am working as hard as I can, as are my staff, with the pharmaceutical company. In the end, it is also a matter for the pharmaceutical company to show us how they can meet the recommendation of the PBAC so that we can give that advice to government and list it.

Senator XENOPHON: So you are hopeful of some resolution of this in the next few weeks?

Ms McNeill: I am working hard to try and do so.

Senator DI NATALE: Are you just negotiating on price at the moment? Is that where you are up to?

Ms McNeill: No, it is not just about price.

Senator DI NATALE: Okay. What are the other issues?

Ms McNeill: There are other issues with respect to the recommendation and how you assess the clinical effectiveness to record that, to maintain the ongoing access under the pay-for-performance arrangement—so, what types of tests, what clinical hurdle, would meet the evidence base that shows that drug continues to work and how well it is working, both working with the company and getting advice from clinicians themselves as to what it is to use this drug in practice and how best to monitor that ongoing effectiveness of the drug.

Senator XENOPHON: Is it the case that Australia is one of the last developed nations to fund this drug?

Ms McNeill: Yes.

Senator XENOPHON: Why is that? You cannot tell me why that is?

Ms McNeill: We were one of the last countries to have the drug brought here for consideration for reimbursement.

Prof. Halton: Let us be clear about this. The drug company have to bring forward a proposal. They did not do that in the same time frame as they did in other countries. And they also have to meet the requirements of the

PBAC which are not all, as Senator Di Natale rightly asked, in respect of price. The reality is that we have to, as we are obliged to legally, get an adequate response from the company in respect of these matters, and we are trying to get that as fast as we can.

Senator XENOPHON: Okay, but we are still one of the last developed countries to have this drug approved for public funding. Is that right?

Ms McNeill: But, again, Senator, we were one of the last countries to have the drug brought here for consideration.

Senator XENOPHON: Right. Thank you.

Senator SMITH: Ms McNeill, if there is anything that we might be able to do as individual senators to encourage the company to respond to queries from the department, we would be very keen to do because it is an issue of concern to all senators. Just going back to two points you made, if I may, one was about the time frame for listing new medicines on the PBS, and in your earlier remarks you mentioned that it is now four weeks faster than it was previously. Can you share with us: what was the average time for the listing of new medicines on the PBS under the previous government? Do you record that figure?

Ms McNeill: I do not have that specifically with me, but what may be of interest to you is the number that we are now listing per month. I can give you that figure. We are now listing an average 20 PBS listings per month, and that compares to an average of eight medicines per month.

Senator SMITH: An average of eight per month previously?

Ms McNeill: Yes.

Senator SMITH: That is a significant improvement.

Ms McNeill: They are two very different numbers, yes.

Senator SMITH: Just explain that. You said they were two very different numbers.

Ms McNeill: Well, yes; one is eight and one is 20.

Senator SMITH: I did not hear that.

Ms McNeill: I was saying that, previously, it was eight per month and now it is 20 per month, and that, yes, they are very different numbers.

Senator SMITH: I see what you are saying. But you can compare the numbers?

Ms McNeill: Yes, they are assessing on the same basis of price increase recommendations from the PBS.

Senator SMITH: That does make sense. You also mentioned in your earlier evidence that there had been changes to co-payments in the past. How long have patient contributions been a feature of the PBS?

Ms McNeill: The first co-payment was introduced in 1960, at 50 pence. Prior to that, the government used to have two categories of PBS co-payments, for general and concessional patients. Concessional patients were people considered pensioners with pensioner health cards and sickness beneficiaries with health benefit cards, and their dependents. Prior to that, other people who held a healthcare card and their dependants, together with some social security pensioners and some veterans' service pensioners were not eligible for the free pharmaceuticals and were treated as general consumers. From 1 January 1983, the new category of concessional consumers was introduced and the three-tier system was put into place. Then, in 1990, the free co-payment access was removed and the alignment of all concessional patients was put into one group, so therefore all concessional patients then made a co-payment contribution rather than just some. There was also an increase in the general co-payment at that time, from $11 to $15.

Senator SMITH: So co-payments or patient contributions have been a feature for over 50 years.

Ms McNeill: That is correct.

Senator SMITH: How many times have there been one-off increases in patient contributions under the PBS?

Ms McNeill: Five until this budget. This budget would make six.

Senator SMITH: Can you identify the dates of the previous five?

Ms McNeill: There was 1983, which was the introduction of the concessional co-payment—but again I note that that was a net spend because it also provided for some people to pay and some people to remain free—and then there was 1986, 1990, 1997, 2005 and the recent budget measure.

Senator SMITH: I am curious to know: do you have statistics on the number of scripts that are dispensed per general patient compared to the number that are dispensed per concessional payment?

Ms McNeill: A general patient on average uses two scripts a year and a concessional patient uses on average seventeen.

Senator SMITH: Excellent. Thank you very much.

Senator CAROL BROWN: It is about the report in the *PharmaDispatch* that Medicines Australia, AusBiotech and the Generic Medicines Industry Association have provided the Minister for Health with a joint position on proposed reforms to the PBS listing process for biosimilars. Can you confirm—I am hesitant to say it because this might be my last question—whether this is true or not?

Ms McNeill: That they provided a proposal?

Senator CAROL BROWN: A joint position to the minister.

Ms McNeill: That is correct.

Senator CAROL BROWN: Can you tell me, then, whether any briefing for the minister on this joint position has been provided to the minister's office, and on what date?

Ms McNeill: I can confirm that we are giving consideration to that. We have not as yet provided advice to the minister.

Senator SIEWERT: Can you tell me how many Aboriginal and Torres Strait Islanders receive support—and take it on notice if you do not have it straight away—through the Close the Gap program please?

Ms McNeill: As at 31 March 2014, there are 258,316.

Senator SIEWERT: That is for the financial year up to the end of March. Is that correct?

Ms McNeill: That is correct.

[14:33]

CHAIR: We are now moving to Outcome 3, access to medical and dental services.

Senator McLUCAS: On what date did the department start modelling for a GP tax?

Dr Bartlett: As the secretary has just pointed out to me, this department has done no modelling on a GP tax. The patient contribution, or co-payment, is not a tax.

Senator McLUCAS: Thank you. On what date did—

Senator MOORE: Chair, over many years in this committee and in other committees in this area, there has been a use of language by senators about things about which there is dispute quite commonly. I draw attention to the whole debate we had about the 'carbon tax' and the way, at that stage, opposition senators consistently talked about changes in that area and referred to it as the carbon tax in this kind of environment. It is a bit too cute, I think, for the department to not acknowledge what is being spoken about. I just want to put that on record.

CHAIR: There is no point of order, Senator Moore. The departmental officials will use the term—

Senator MOORE: And we will continue to use ours.

CHAIR: You are more than welcome to, but you can expect that there would be a response to that, as I am sure there has been on many previous occasions. Where were we?

Senator O'NEILL: Waiting for an answer to the question, I think.

Senator McLUCAS: Dr Bartlett, what is the term that you use to describe the GP tax?

Dr Bartlett: Patient contribution or co-payment.

Senator MOORE: That is very catchy.

Senator McLUCAS: On what date did the department start modelling for the $7 co-payment to go and see the doctor?

Senator O'NEILL: The GP tax?

Senator McLUCAS: Sometimes called the GP tax.

Dr Bartlett: I would have to check to give you an exact date—I would have to take that on notice.

Senator McLUCAS: I would like you to do that. What specific item numbers does the tax apply to?

Dr Bartlett: The co-payment applies to a range of items. It applies to 52 GP items. I can give you details on those.

Senator McLUCAS: If you have a document that describes that, rather than reading them out to us, and you could hand that up that would be fantastic.

Dr Bartlett: Yes, I can provide you with that.

Senator McLUCAS: Thank you. So 52 GP items—

Dr Bartlett: It also applies to all out-of-hospital pathology and all out-of-hospital diagnostic imaging. Clearly, there are a significant number of items covered under both of those specialties.

Senator McLUCAS: I understand that.

Senator POLLEY: If you go to pathology and you have to have 11 tests of your blood, is that going to cost you $77?

Dr Bartlett: No. The co-payment will apply once per episode. The other point I should make is that, under the existing pathology funding arrangements, if the tests are requested by a GP, the first three tests are paid for—but the co-payment will apply once per episode.

Senator POLLEY: No matter how many tests you are having?

Dr Bartlett: Correct.

Senator POLLEY: So I suppose you would just save up the opportunities to go and get your blood tested.

Senator McLUCAS: Once the medical research fund reaches this $20 billion, is it envisaged that the co-payment or tax will be stopped?

Dr Bartlett: That is a decision for government.

Senator McLUCAS: Is that the view of the government?

Senator Nash: I am not aware of consideration of that matter.

Senator McLUCAS: So we will just keep charging it ad infinitum?

Senator Nash: No, I said I am not aware of consideration of that matter.

Senator McLUCAS: Maybe you could find that out for us.

Senator Nash: I can undertake to do that for you.

Senator McLUCAS: Going to exemptions, you would have heard lots of different cohorts of the community talking about needing to be exempted from the co-payment or tax. Have there been any exemptions agreed to this point in time?

Dr Bartlett: No.

Senator McLUCAS: None at all?

Dr Bartlett: No—sorry, let me correct that. Veterans under the DVA arrangements are not covered by these arrangements.

Senator McLUCAS: And those costs are covered in DVA?

Dr Bartlett: It is covered under a separate appropriation that is run by a separate department.

Senator McLUCAS: Are you aware that representatives of Indigenous peoples have requested that their patients be exempted from paying the GP co-payment or tax?

Dr Bartlett: I think the minister is in a better position to comment on that than I am.

Senator Nash: I am aware of that, yes.

Senator McLUCAS: Are those requests for exemption being considered?

Senator Nash: I can indicate to you that I met recently with a number of Indigenous organisations who raised that with me. I am not aware of or privy to any discussions they may have had with other ministers.

Senator McLUCAS: Is their request for exemption being considered?

Senator Nash: I am not aware. All I can do is indicate to you is that I have had discussions with those in the sector.

Senator McLUCAS: Are you advocating to the minister that Indigenous Peoples be exempted?

Senator Nash: I have not had discussions with the minister about this.

Senator McLUCAS: You did not talk to the minister following your meeting with Indigenous organisations?

Senator Nash: No, I do not think I have had the opportunity to have a discussion with him since. It was quite recent.

Senator McLUCAS: What about people with MS? Are you aware that people with MS have been requesting that they be exempted from the copayment or tax?

Senator Nash: I am not aware.

Senator McLUCAS: Can you find out whether there is consideration of any other cohort that is being undertaken at the moment for those groups of people to be exempted from paying the copayment or the tax?

Senator Nash: Insofar as I can, I will certainly undertake that for you.

Senator McLUCAS: The low gap incentive amounts, which I think we used to call the bulk billing incentive—am I right to correlate those two sets of language?

Dr Bartlett: You are, Senator.

Senator McLUCAS: So we used to call it the bulk billing incentive, but we cannot call it that anymore because no one will be bulk billed in Australia.

Senator Nash: Sorry, Senator, can I just—

Senator McLUCAS: No, I was actually asking a question. Please do not interrupt me. I get in trouble for doing the same to you.

Senator Nash: You were making a statement that no one would be bulk billed. I want to clarify that general practitioners, as they have in the past, will still have the option to either bulk bill or charge a fee.

CHAIR: Thank you for that clarification minister.

Senator McLUCAS: The incentives are currently $6 for metropolitan areas and $9 for rural and regional. Will they apply as they do for bulk billing or do those amounts intend to change?

Dr Bartlett: Those amounts will be indexed twice between now and when they apply from 1 July next year.

Senator McLUCAS: At what indexation rate?

Dr Bartlett: Wage cost index.

Senator McLUCAS: You have answered the question about veterans being affected. I might come back to how those bulk billing incentives—or low gap incentives—will work into the future. What happens to nurse incentive items?

Dr Bartlett: There is a practice nurse incentive program which is completely separate to the MBS.

Senator McLUCAS: They are not affected?

Dr Bartlett: You would have to ask the Health Workforce division. I think they are the division responsible, but I am not aware.

Senator McLUCAS: Let us go to the nitty gritty, and Senator Di Natale will have some views on this as well. Let us talk about item no. 23, which I understand is a 15 minute consult.

Dr Bartlett: It is a consult up to 20 minutes.

Senator McLUCAS: At the moment, the rebate is how much for a 15 minute consultation?

CHAIR: It is a 20 minute consultation.

Dr Bartlett: Up to 20 minutes. It is $36.30.

Senator McLUCAS: With the new regime, what happens?

Dr Bartlett: The rebate reduces by $5 to $31.30. If you are patient billed, then the doctor will charge you what you are charged, and you will get a rebate of $31.30. If the doctor bulk bills you and you are a non-concessional, the doctor charges you a $7 copayment and the doctor will get the $31.30 plus the $7 that you have paid.

Senator McLUCAS: Yes.

Dr Bartlett: If you are a concessional then the doctor will charge you $7. The doctor will get $31.30 plus the relevant low gap incentive—$6 in metropolitan areas and $9.10 in rural and regional areas. The secretary has again reminded me that concessionals are concession-card holders and children under the age of 16. I should finish by saying that that will apply for the first 10 visits—GPs, pathology, diagnostic imaging. After the 10th visit the rebate returns to $36.30 and the doctor then gets an incentive for effectively bulk-billing you for subsequent visits.

Senator McLUCAS: You know how doctors run their practices as private businesses, have you worked out what will happen?

Dr Bartlett: I am sorry, but I am not understanding.

Senator McLUCAS: In the same way that I was asking questions around the PBS, I am trying to ask questions about what will happen with the MBS and the behaviour of doctors and patients. Has any modelling been done around what you expect to happen to doctors' billing practice?

Dr Bartlett: As the minister has said, there is an estimate that GP consultation numbers will continue to rise but the rate of growth will be about one per cent less than it currently is. In the first year in which this arrangement operates the number of GP consultations will continue to grow but the rate of growth will be one per cent lower than it otherwise would have been.

Senator McLUCAS: How did you come to that figure of one per cent lower?

Dr Bartlett: It is an estimate. It is based on a range of things. It includes things such as looking at what has happened with other co-payments here. It includes looking at the research overseas and at what happens in other countries. The picture is very mixed, and it is an estimate based on that very mixed evidence.

Senator McLUCAS: It is interesting that we have done that for the MBS, but not for the PBS. What is one per cent of consultations? How many foregone consultations do we expect because of this?

Dr Bartlett: There are currently 120 million consultations in a 12-month period. As I said, we anticipate that GP consultations will continue to grow in the first year of the arrangement. We anticipate they will grow by about 3.7 per cent.

Senator McLUCAS: But with a one per cent reduction because of the impact—

Dr Bartlett: We anticipate that the rate of growth will be lower than it may otherwise have been. As I say, Senator, these are estimates.

Senator DI NATALE: The one per cent is essentially an acknowledgement that demand for general practice services will reduce.

Dr Bartlett: No, Senator. As I have said a couple of times, demand for GP services will continue to grow.

Senator DI NATALE: That demand will be impacted upon by the co-payment.

Dr Bartlett: Yes. It has been commented that growth on demand will impacted upon.

Senator DI NATALE: In other words, the result of this co-payment is that some people who would have chosen to go to the doctor will no longer go. I will not go into the reasons, but that is what we can take out of that one per cent reduction.

Dr Bartlett: Yes, Senator.

Senator DI NATALE: I do not know if we have had that acknowledgement before. We have not had the opportunity to talk to you about this before. The international evidence you have been talking about, did you look at the RAND study, for example?

Dr Bartlett: Yes, Senator.

Senator DI NATALE: One of the outcomes of the RAND study was that some people who would otherwise have gone for blood-pressure monitoring and other visits no longer saw their primary care physician as a result of the co-payment.

Dr Bartlett: The RAND study took four cohorts, as I understand it. There was a cohort that got free services; there was a cohort that was paying 25 per cent of the cost of their service. There was one that was paying 50 per cent and one that was paying 95 per cent of the cost. The $7 that is being talked about here for item 23 is well under the 25 per cent threshold. There are general comments made in the RAND study about what the effects were, but the overall comment about the impact and who is affected varies because it is clustered across the three thresholds.

Senator DI NATALE: Yes, but the take-home message from the RAND study was that some unnecessary visits were deterred but also that people who should have seen their GP were also deterred as a result of the co-payment.

Dr Bartlett: Yes, across the three groups that went.

Senator DI NATALE: Of the $3.5 billion, how much of that comes from reduced demand?

Dr Bartlett: The overwhelming amount comes from the $5 reduction—

Senator DI NATALE: Have you separated the two?

Dr Bartlett: I do not have those numbers.

Senator DI NATALE: Is it fair to say that the impact on demand was one of the considerations around the introduction of the co-payment? In other words, you only need a few people to stay away from the GP to make a saving of $40 but you need a lot more people to be charged a co-payment of $5.

Dr Bartlett: That is a valid mathematical point. I think the government has made a series of comments about seeing the importance of price signalling for these various services.

Senator DI NATALE: You have not done any modelling to separate how much is from demand reduction and how much is from the impact of the co-payment?

Dr Bartlett: The figures in the forward estimates reflect the combination of the two.

Senator DI NATALE: Are you worried that some of the people who would be deterred are people who might otherwise bring their kids to a GP to get vaccinated?

Dr Bartlett: There are a range of options for vaccination which will continue to be available. There are public health clinics that will continue to provide services. There are a range of ways in which people can access immunisation. I do not see how that will change.

Senator DI NATALE: A lot of people take their kids to the GP to get vaccinated. Are you worried that they will not do that as a result of the fact that they might be in this group of one percent of people who otherwise would have gone to a doctor?

Dr Bartlett: I do not see any reason why that would be the case. I think, for example, if you look at Canberra—children in Canberra get immunised.

Senator DI NATALE: Do you know what the average income is in Canberra compared to some other parts of the country?

Dr Bartlett: But the point I am making is that if you look at the range of places, and Canberra is not—

Senator DI NATALE: Canberra is not representative of the rest of Australia, Dr Bartlett.

Dr Bartlett: Yes, and the co-payments in Canberra are not representative of the rest of Canberra either.

Senator DI NATALE: That is right.

Dr Bartlett: But children get immunised in Canberra.

Senator DI NATALE: Yes, I know. What is the mean income in Canberra?

Dr Bartlett: I do not know.

Senator DI NATALE: I bet it is about double what it is in the rest of the country.

Prof. Halton: It is also the case that there are significant numbers of low-income people in this town. The point that Dr Bartlett is making is that they immunise their kids too, notwithstanding the co-payments that they pay in this town, which I am sure Senator Seselja can tell you about.

Senator DI NATALE: I think we have just confirmed a lot of the criticism that is levelled at people not necessarily being in touch with how tough some ordinary people are doing it at the moment.

Senator Nash: Senator, I do have to pull you up on that. What exactly did you mean by that?

Senator DI NATALE: Minister, I do not think you can compare the experiences of people in Canberra with the experiences of people in the rest of the country.

Senator SMITH: So the views of people in Canberra do not matter?

Senator DI NATALE: Of course they matter. But you cannot extrapolate that, simply because in Canberra we have bulk-billing rates, that the impact of bulk-billing in Canberra is somehow similar to the rest of the country. The average income in Canberra is much higher than it is in the rest of the country.

Senator Nash: It was particularly the bit about being out of touch, Senator Di Natale. I think we are very well in touch with the feelings on the ground. As the secretary said very clearly, there are a lot of people living in low socioeconomic circumstances who are immunising their children. I think it was a gross generalisation to say that we are disconnected because we took Canberra into account for one particular circumstance.

Senator DI NATALE: If you are basing your modelling on the experience of people in Canberra, then I suspect you are very much out of touch with what is going on in the rest of Australia.

Senator Nash: I do not think that was the basis of the modelling. You know that, Senator.

Dr Bartlett: Can I make a point here?

Senator DI NATALE: Yes, sure.

Dr Bartlett: I cited the area with the lowest bulk-billing rate for a reason. You can make similar points about a whole range of other regions in the country. Bulk-billing rates vary significantly across the country. They are not uniform. On the other hand, immunisation rates are uniformly high.

Senator DI NATALE: Are you saying there is no variation in immunisations?

Dr Bartlett: There is variation, but they are high across the country, and the reason they seem to vary is—

Prof. Halton: If you want to go where there are low immunisation rates, weirdly, it does seem to be in high-income communities—in the eastern suburbs of Sydney, for example.

Dr Bartlett: And it is a big problem.

Prof. Halton: It is a big problem.

Dr Bartlett: I think there is a point to be made about that, which says that it is not just about Canberra. You can actually make that point about immunisation more broadly and the lack of connection between bulk billing rates.

Senator SESELJA: I do not know quite where to start on the Canberra criticism from Senator Di Natale. I want to go into another area, just to clarify the point as well. I think the point was made by Professor Halton that when you are considering Canberra, like considering any other regions, you take into account the fact that Canberra has a significant number of families who have low incomes and who do it tough and yet we still see high immunisation rates. Was that broadly the point that we were hearing?

Prof. Halton: Correct.

Senator SESELJA: Rather than the idea that Senator Di Natale was trying to express there, which is that all Canberrans are very comfortable and very wealthy. We know that is not the case.

Prof. Halton: Correct.

Senator SESELJA: I just wanted to go to the Medicare Benefits Schedule and just get some of the numbers around the sustainability of it and some of what the government is trying to address. What is the current spend on the Medicare Benefits Schedule this financial year?

Dr Bartlett: In 2012-13, so last year, the spend was $18.6 billion.

Senator SESELJA: How does that compare to a decade ago? How much has that grown in the last decade?

Dr Bartlett: In 2002-03, the spend was $8.1 billion.

Senator SESELJA: In 11 years, it has gone up by roughly $10.5 billion or more than double. What is the projected spend on the Medicare Benefits Schedule in the decade from now if there was no change? That is, if we did not change anything that is in place at the moment, prior to decisions taken by this government.

Dr Bartlett: It is approximately $34 billion.

Senator SESELJA: It would go up, effectively, in 20 years—from the 2002-03 to 10 years from now or 21 years—by about a fourfold, from around $8.1 billion projected to about $34 billion. How much does the government receive from the Medicare levy and the Medicare levy surcharge?

Dr Bartlett: In 2011-12, the Medicare levy and Medicare levy surcharge together generated a revenue of $9.28 billion.

Senator SESELJA: That is roughly 50 per cent of the spend on the Medicare Benefits Schedule.

Dr Bartlett: It is roughly 50 per cent of the spend on the Medicare Benefits Schedule. It is 16 per cent of total Commonwealth health expenditure.

Senator SESELJA: I suppose there would not be projections—to do a like-for-like, for currently and then—on how much we are expecting to spend on the Medicare Benefits Schedule in a decade if nothing changed. But presumably you would not have projections for how much we might be expecting to get from the Medicare levy and the Medicare levy surcharge in a decade.

Dr Bartlett: Those sorts of estimates, if they exist, are the responsibility of Treasury and certainly not ours.

Senator SESELJA: I figured that you probably would not have those. At the moment, basically 50 per cent just of funding for the Medicare Benefits Schedule—not overall Commonwealth health spending, but roughly 50 per cent—comes or is funded by the Medicare levy and Medicare levy surcharge. On the MBS co-payment safety net, if a patient reaches the safety net, what is the maximum per week they can expect to pay over the year, averaged out?

Dr Bartlett: For a concessional co-payment, assuming that their doctor essentially goes through and charges them the $7 co-payment, the maximum amount paid before the safety net kicks in is $70.

Senator SESELJA: So roughly a little less than $1.50 a week, averaged out, would be the maximum someone eligible for the safety net would pay over the year.

Dr Bartlett: That is correct.

Senator SESELJA: Going to other areas for the Medicare Benefits Schedule, how much does the government contribute to pathology through the Medicare Benefits Schedule?

Dr Bartlett: For out-of-hospital pathology in 2012-13, the total expenditure was $2.14 billion.

CHAIR: Million or billion?

Dr Bartlett: Billion. It was $2.14 billion. Of that $2.14 billion, 98.5 per cent was paid for by government and 1.5 per cent was paid by patients.

Senator SESELJA: That is the total. What is the dollar amount?

Dr Bartlett: I do not have that, but it is around $300 million.

Senator SESELJA: In terms of that 1.5 per cent, is that the average that patients would current contribute towards pathology services?

Dr Bartlett: That is the total amount paid by patients across the board, as a percentage of the total amount paid.

Senator SESELJA: It is 1.5 per cent versus 98.5 per cent contributed by the government at this stage. How does the contribution patients make to pathology compare to patient contributions to pharmaceuticals?

Dr Bartlett: My understanding, from my colleagues in Pharmaceutical Benefits, is that the pharmaceutical split is 86 per cent government and 14 per cent patients.

Senator SESELJA: At the moment, there is a greater contribution made by people who are making the co-payment for pharmaceuticals than there is for people who are paying part of the cost for pathology.

Dr Bartlett: That is correct.

Senator SESELJA: Do we know the current bulk billing rate for pathology services?

Dr Bartlett: Yes, it is 87.7 per cent. That is for all pathology. For out-of-hospital pathology, it is well over 90 per cent.

Senator SESELJA: Do we know how that compares with the number of people on healthcare cards?

Dr Bartlett: About 37 per cent of people are concessionals, on healthcare cards or children under 16. They use about 50 per cent of services.

Senator SESELJA: They use 50 per cent and presumably they bulk bill them. Presumably, there is another 37 per cent or so that are also bulk billed.

Dr Bartlett: That is correct.

Senator SESELJA: Just on radiology, how much does the government spend on radiology through the Medicare Benefits Schedule?

Dr Bartlett: For out-of-hospital radiology in 2012-13, it was $2.83 billion.

Senator SESELJA: Do you have the level of bulk billing in radiology?

Dr Bartlett: It is around about 75.9 per cent for the latest quarter. In 2013-14, for the first nine months, it is 75.9 per cent.

Senator SESELJA: Likewise with the number we got in terms of the amount of consultations used by people with healthcare cards, is there a similar number you have for radiology?

Dr Bartlett: The breakdown is broadly similar. There may be a couple of percentage variations in terms of the service utilisation, but the 37 per cent is a constant number and the round about 50 per cent is fairly consistent too.

Senator SESELJA: Around about 50 per cent is the utilised rate.

CHAIR: In the committee's hands, do you want to go back to the general stuff or get through the specific stuff first?

Senator McLUCAS: I would not mind staying on the MBS.

CHAIR: That is fine.

Senator McLUCAS: Going to the costs of the GP proportion of the total health budget, can you indicate, Dr Bartlett, what is happening with that trend? As a proportion of total health expenditure, which way is GP spending trending?

Dr Bartlett: Total GP benefits for 2012-13 were $5.9 billion; that was up from $5.58 billion the year before.

Senator McLUCAS: I am asking as a proportion of total health expenditure.

Dr Bartlett: Total health or total Medicare?

Senator McLUCAS: Total Medicare expenditure on GP item numbers.

Dr Bartlett: I would have to do the calculation in my head, and that is always risky, but you have about $6 billion being paid for GPs and about $18½ billion overall. So it is just under about a third.

Senator McLUCAS: I think it is relevant to the conversation that was just had, though, that between 1996 and 2013 the percentage of GP item numbers as a proportion of total Medicare expenditure dropped from 33.6 per cent to 27.2 per cent. They are figures from DHS.

Dr Bartlett: Are you talking about percentage of services rather than benefits?

Senator McLUCAS: Total Medicare expenditure on GP item numbers, unreferred attendances, as a proportion of total Medicare expenditure.

Dr Bartlett: Yes, but that will reflect the fact that the MBS has broadened significantly over that period of time to cover things like allied health; dental, for a period of time; and a range of other things.

Senator McLUCAS: Certainly, and that is a good thing. But to indicate or to imply that GP costs are going up exponentially—the figures do not support the proposition.

Senator SESELJA: I am not sure where the implication was. I asked a series of questions around the cost, and the numbers spoke for themselves.

Senator McLUCAS: I was reading between your lines, which is probably dangerous.

Senator SESELJA: Were there any issues you had with the numbers? Were any of the numbers wrong?

Senator McLUCAS: No, Dr Bartlett's numbers are always correct.

Senator SESELJA: I am glad we have clarified that.

Dr Bartlett: I wish!

CHAIR: Just bask in the glow, Dr Bartlett!

Senator McLUCAS: Can I go back to the bulk-billing again. I know it is tedious and boring. Can we go back to item 23 and what will happen once the $7 GP tax, or co-payment, is applied? Can you walk us through that again? I think we really need to better understand this.

Dr Bartlett: Starting with the easiest one first, if you are a doctor-billed patient and you are charged an amount over and above the $36.30—you are charged, say, $70—

Senator McLUCAS: Let's just deal with the 80 per cent of those attendances which are bulk billed.

Dr Bartlett: If you are a concessional patient then what will happen is, if the doctor bills you a $7 co-payment, the doctor will then be able to get $31.30 as the rebate for the service; and, if you are concessional, they will get the relevant low gap incentive—$6 in metropolitan areas, $9.10 in regional areas.

Senator McLUCAS: Can I just say that back to you so that I have this absolutely clear. So, if you go to the doctor and the doctor says, 'That will be $38.30,' which is $31.30 plus $7, and you are concessional, the doctor will also receive $6 bulk-billing incentive, or $9 bulk-billing incentive, now called the low gap incentive?

Dr Bartlett: That is correct.

Senator McLUCAS: And if you are not concessional, if you are a general patient, what happens?

Dr Bartlett: What happens now is the doctor, if they bulk-bill you, gets $36.30; they do not get any incentive. If the doctor chooses to charge you a co-payment of $7, then the doctor will get $31.30 from the government and $7 from the patient, for a total of $38.30.

Senator McLUCAS: So, if you are a general patient now and you go to the doctor and the doctor bulk-bills you, you do not get the $6 and $9 bulk-billing incentive?

Dr Bartlett: No.

Senator McLUCAS: So the incentive to bulk-bill a concessional payment in a city will mean the doctor actually takes home $1 less, per item 23. Is that right?

Dr Bartlett: I do not understand that, no. There is a $5 rebate reduction and they get a $7 co-payment; that is $2 extra, all other things being equal.

Senator McLUCAS: $31.30 plus seven plus six or nine.

Senator DI NATALE: Just to clarify Senator McLucas's point, the $6 incentive for bulk-billing is for concessional card holders at the moment—and kids—and it does not change under this new arrangement?

Prof. Halton: That is correct.

Senator DI NATALE: Do you still call it bulk-billing?

Prof. Halton: Low gap.

Dr Bartlett: Low-gap incentive.

Senator DI NATALE: Has the phrase 'bulk-billing' disappeared now from the lexicon? Is there any such thing as bulk-billing anymore? Are you struggling with that? Because I struggle a bit with that.

Dr Bartlett: Bulk-billing as it stands actually talks about the fact that the patient can assign the rights to their rebate to the doctor. The capacity to do that continues under this measure.

Senator DI NATALE: That is not how people understand it.

Prof. Halton: No. There is a difference here, isn't there, between the origins of what the actual label means, which does have a particular technical meaning. Under the legislation that technical meaning is actually still there and continues. And of course the truth is that if you are a general patient you are in one category. If you are a concessional patient and you have done 10, as Dr Bartlett has already outlined, the rebate that is provided actually escalates by the $5 and the expectation would therefore be that you would, if you got to 11 services—assuming the doctor behaves in the same way—you would receive that without a co-pay.

Senator McLUCAS: Coming back to the way it will work, Minister Dutton has said that doctors do not have to charge this extra $7.

Prof. Halton: It is not mandatory.

Senator McLUCAS: It is not mandatory. Let us walk through what happens to a doctor's practice if the doctor decides not to charge the $7 co-payment. If the doctor does not charge the $7 co-payment to a concessional patient, what happens then?

Dr Bartlett: The doctor will get $31.30 for the item 23 service.

Senator McLUCAS: So that is a difference between—$31.30—

Dr Bartlett: Plus whatever they charge the patient—assuming it is not $7.

Senator McLUCAS: How can the doctor do that, if they are saying they are not going to charge?

Prof. Halton: They may charge a fee—

Senator McLUCAS: So the doctor says okay, I am not going to charge you anything more than what I get off the NBS. The difference for that 20 minutes of remuneration is $31.30 plus seven plus, metropolitan, six.

Senator DI NATALE: So they are not entitled to the bulk-billing incentive if they do not charge a co-payment. That is correct, isn't it?

Prof. Halton: The $7.

Dr Bartlett: They have to charge a $7 co-payment for the first—

Senator McLUCAS: So it is actually the opposite of the bulk-billing incentive.

Senator DI NATALE: But even though you are bulk-billing, the fact that you are not charging a co-payment means that you are penalising the doctor for bulk-billing the patient. I do not get that bit.

CHAIR: I think this is where Senator McLucas is trying to head. I do not think we have got there in time for your commentary, Senator Di Natale.

Senator DI NATALE: Senator McLucas has already said she does not mind me interrupting from time to time.

CHAIR: With questions!

Senator McLUCAS: The difference will be, for a doctor who says, 'I'm not going to charge the co-payment', that for a 20-minute consultation if you do not charge, if you follow Minister Dutton's advice, that doctor will receive $31.30 for that 20 minutes. Alternatively, if it is a concessional patient they would get $44.30. Are my figures correct?

Prof. Halton: No, that is not right.

Dr Bartlett: If you do not charge a $7 co-payment—

Senator McLUCAS: Sorry—if you do charge the $7 co-payment. It is the fact that we turned bulk-billing on its head. We used to incentivise bulk-billing; now what we are doing is incentivising not bulk-billing. That is where we are.

Senator DI NATALE: That is exactly right.

Senator McLUCAS: So, if the doctor does charge the GP tax or co-payment they get $31.30 plus $7—the $7 from the patient—plus $6 from the low—

Dr Bartlett: Low-gap incentive.

Senator McLUCAS: The low-gap incentive, to add up to $44.30—I hope.

Dr Bartlett: That sounds right.

Senator McLUCAS: So, where is the incentive to do what Minister Dutton says, and that is, don't charge it? Three times 20 minutes is an hour. That is a lot of money that you are saying to the doctor, 'You've just go to absorb this.'

Senator Nash: The minister is being very clear in saying the arrangements have not changed, that GPs can still choose to bulk-bill or charge a fee—I do not think he has given any directive.

Senator DI NATALE: They will be punished for it if they do though.

Senator McLUCAS: There have been some doctors who, very generously, have said they will continue to just receive the MBS item number remuneration—but gee it is going to have an impact on the operation of the services!

Senator DI NATALE: Why isn't the $6 incentive to bulk-bill being applied to doctors who decide they may waive the co-payment? Why don't they get the $6?

Prof. Halton: That is a decision of the government. The incentive is to have a low gap for the first 10 consultations for concessionals and children. That is the decision of the government.

Senator DI NATALE: I just do not understand the public policy rationale behind it. Minister Nash, if a concessional patient comes in and the doctor says they are not going to charge you a co-payment but they are also—

Senator McLUCAS: I do not have any money in my pocket to pay you!

Senator Nash: I think we have been very clear about the sustainability we need to have for the future of the health system. It is vitally important that we get that right. We run through the numbers before. We have gone from a cost of $8 billion for the MBS 10 years ago. In 2007-08 it was $13 billion and it has gone up to a bit over $18½ billion now. It is projected to go to $34 billion. We have got 263 million free services occurring at the moment. That is unsustainable. As has been very clearly pointed out, we have chosen with the co-payment to put in place a change to the system which we believe will make the system sustainable. Indeed, any fiscally responsible government would be ensuring that the health system is sustainable into the future. I take the comments about GPs and how they charge. Many GPs both bulk-bill and charge a fee. Obviously there will be the change of arrangements with the bulk-billing reimbursement, but there will also be a $2 increase in a standard consultation for the GP should they choose to do that.

Senator McLUCAS: I think that is a problem there. When you go to the doctor, you want to get some health services; you do not want to plead with them and tell them you are very poor. That is not the nature of transactions in our health system; you do not have to show your bank balance and say: 'I'm sorry, I haven't got any money. Do you mind taking a cut of $13 for this 20-minute consultation because I'm poor?' That is not the way we run our health system in this country. But that is what you are proposing; that is what you have just said.

Senator Nash: I can only reiterate that we have made these decisions so that we have a sustainable health system into the future. Unlike the previous government, we do not think it is in any way sustainable to have the MBS running out to $34 billion in 10 years time. We have had to make some tough decisions across the budget because of the economic mess that was left to us by the previous Labor government, by your government. I know you do not like hearing that, but it is a fact.

Senator McLUCAS: Because it is not true.

Senator Nash: It is indeed true. You cannot say that spending $1 billion a month on interest for the debt that you racked up—over $30 million a day in interest, which could build a new teaching hospital in every city around the country—is in any way leaving us in an economically responsible situation.

Senator McLUCAS: A lot of economists do not agree with you.

Senator SESELJA: I think the Parliamentary Budget Office does.

Senator Nash: Senator McLucas, I know you do not want to hear it, but it is a fact. We made decisions around health delivery to ensure that we do have a sustainable system into the future.

Senator McLUCAS: And poor and sick people pay. But the question is: 'What proportion—

Senator Nash: No. I am going to pull you up there. GPs have the option to bulk-bill or not. It is incorrect to characterise that as 'poor people have to pay'.

Senator McLUCAS: What proportion of patients are likely to meet the 10 visit cap in a year?

Dr Bartlett: The average concessional patient will get beyond the cap of 10 visits.

Senator McLUCAS: What is the average presentation for a concessional patient?

Dr Bartlett: The average concessional patient goes to the GP about nine times a year. They get around three pathology episodes and one DI episode.

Senator McLUCAS: What proportion of the total number of concession card holders will meet the cap?

Dr Bartlett: It is an average. I can go back and get you a number about that, but, as I say, when you take the total number of visits and divide them, that is where you get to for the various groups.

Senator McLUCAS: So it is the number of concession card holders divided by two, or not?

Dr Bartlett: No.

Senator McLUCAS: I did not think so. So can we have the number, please?

Dr Bartlett: I think we are getting means and medians. I do not have the median; I would have to get that for you on notice.

Senator McLUCAS: I was told the number of concession card holders earlier. Can you provide for me the number of people who are concession card holders and the number of people who on your predictions will hit 10 items?

Dr Bartlett: I can provide you with the number of concession card holders. I can provide you with the number of people who would have hit the threshold during 2012-13.

Senator McLUCAS: Thank you. Also, how many general patients will hit the 10 visits per year?

Dr Bartlett: I can provide that, but I can tell you that the average number of GP visits in a 12-month period is about 5.6. That is for the whole population across the board; so the average number of visits for non-concession card holders is down around three. The average number of pathology episodes overall is about 1.4 and the average number of DI episodes is about 0.8. So you get a very different mix there than you do with the concessionals.

Senator McLUCAS: You will be able to provide me with the same figure that is an analysis of a general patient?

Dr Bartlett: Yes.

Senator DI NATALE: Could you provide the medians? Obviously the median and the average give a different view. You may have a small number of people who have 100 visits a year, which skews the numbers completely. So the median would be much more useful.

Dr Bartlett: We can provide both.

Senator McLUCAS: The median and the actual number.

Dr Bartlett: Yes.

Senator McLUCAS: Does the 10 visit cap apply to families, or individuals?

Dr Bartlett: Individuals.

Senator McLUCAS: If a family of four all go to the doctor on the same day, that is four visits?

Dr Bartlett: Yes.

Senator McLUCAS: But allocated to each person?

Dr Bartlett: Yes, depending on how the doctor does it. I certainly know of cases where the doctor will see two members of a family at once and charge one fee. A range of things happen.

Senator McLUCAS: So that is counted for one of those individuals as one of their 10—before you get to the magic time when the world changes.

Dr Bartlett: Yes.

Senator McLUCAS: Can I go to Aboriginal Medical Services. Last Friday we asked questions on how the GP tax, or co-payment, will apply to AMSs, and we were referred to this element of our estimates. Can you walk through what modelling or figuring you have done around how AMSs will work?

Dr Bartlett: My understanding is that AMSs get a very significant amount of money through grants and other funding. MBS funding is an add-on. The total MBS funding that went to AMSs in 2012-13 was $51 million. Of that, $20 million, or nearly 40 per cent, is for items that are not covered under this measure and so will not incur a co-payment. That means the total amount of money related to services which are covered under this is $31

million. The net amount that is potentially at risk, as I understand it, in this is between $5 million and $6 million, across 116 AMSs.

Senator McLUCAS: Sorry, I do not understand what you mean.

Dr Bartlett: They still get paid the MBS rebate. Should they make a decisions to continue to bulk-bill, as opposed to charging a co-payment, then clearly, as you have gone through, there is a potential sum of money at risk. The potential sum of money at risk, on our calculations, is between $5 million and $6 million, across 116 AMSs.

Senator McLUCAS: How did you do that work?

Dr Bartlett: We have gone through and had a look at the services and basically tried to model what would happen. Sorry, 'model' is the wrong word; I should say 'estimate'.

Senator McLUCAS: We are not allowed to use 'model' anymore.

Prof. Halton: This is about behaviour, and it is very hard to 'model' it; you can apply a series of expert opinions to them.

Senator McLUCAS: So you are saying there is between $5 million and $6 million that you expect will not go to Aboriginal Medical Services because you think that—

Dr Bartlett: No, that is not what I said. I said that, depending on choices people make and depending on comments people make, you can make an interpretation about the maximum amount of money that is potentially at risk—and that is the number I am giving you.

Senator McLUCAS: And that is the amount the $31.30 and $44.30?

Dr Bartlett: No. It will be a mix of the change of benefit and other factors.

Senator McLUCAS: To do that thinking, are you working on the basis that no co-payment will be charged at all?

Dr Bartlett: I am not working on that basis. I am saying that, if that happened, the maximum amount of the risk is between $5 million and $6 million. I do not know what the choices will be. There are very high bulk-billing rates in AMSs at the moment, but there are patients who are charged co-payments. And the co-payment, when charged—and it is in a small numbers of cases—is around $27 or $28.

Senator SIEWERT: You are trying to make it sound less by saying it is through 116 AMSs, but actually 20 per cent of the $31 million could be affected?

Dr Bartlett: That is potentially the amount that is there. But, as I said, that is 20 per cent of 60 per cent.

Senator SIEWERT: That is a significant amount to AMSs.

Senator McLUCAS: It is 20 per cent of your income.

Dr Bartlett: It is not 20 per cent of your income.

Senator SIEWERT: It is 20 per cent of the amount.

Dr Bartlett: No. As I went through, there is a significant amount of grant income—in the hundreds of millions of dollars—and then there is the MBS, which is $50 million. Of that $50 million, $20 million has no impact on it because it covers health checks and a range of other things. That then gets you down to $30 million and, of that $30 million—

Senator SIEWERT: You said it was $5 million $6 million. Is that not 20 per cent of the $31 million?

Dr Bartlett: It is 21 per cent of that number.

Prof. Halton: Let us be really clear about this. It has always been the case that the lion's share, the big majority, of funding going to AMSs actually comes from grant funding. As Dr Bartlett has outlined, that is in the hundreds of millions of dollars a year category. So hundreds of millions of dollars a year is provided in grants. And then there is tens of millions of dollars provided under a series of MBS items around particular activities—health checks. And then there is a small amount, which is these attendance items. So if you look at the proportion that is potentially at risk—noting that already some AMSs charge a co-payment; it is not true that AMSs universally do not charge people— there is some money at risk. But, as a proportion of the total funding that goes to AMSs, this is not the lion's share; it is a small proportion. That is the point I think Dr Bartlett is making.

Dr Bartlett: That is exactly the point I am making.

Senator McLUCAS: What is the proportion of MBS item numbers that are bulk-billed that are delivered through AMSs?

Dr Bartlett: Around 99 per cent.

Senator McLUCAS: So there is not much that has got a co-payment on it?

Dr Bartlett: But there are some.

Senator McLUCAS: So what assumptions did you use to do the figuring to get to somewhere between $5 million and $6 billion being at risk? Did you work that on the basis that 99 per cent of patients are bulk-billed because they have got no money in their pocket?

Dr Bartlett: I cannot comment on whether patients have money in their pocket; all I can say is that, in terms of what we did, we said there is this percentage and this number of items being bulk-billed at the moment. Doing the calculation based on those—noting that the amount of money at risk does not change but the percentage of the total amount paid does, depending on whether it is a level B, C, or D item—we come up with $5 million or $6 million as the number at risk. But we have made no assessment as to what the outcome will be.

Senator McLUCAS: What were the assumptions that you put into that?

Dr Bartlett: We looked at the existing services. On the assumption that existing behaviour continues—and it is an assumption, or an estimates parameter if you like—the amount of money at risk is in the order of $5 million to $6 million.

Senator SIEWERT: You said then 'if the behaviour continues'. But what happens if they do charge and the number of people going to the GP decreases? Have you looked at that?

Dr Bartlett: As the secretary has just gone through, there are a whole range of things in place at the moment to try and ensure, mainly through grant funding, that primary care services for Indigenous people are available through AMSs. That will continue to be the case. They have all got choices they can make but, in terms of what has been talked about, this group has a very small percentage of risk. So, presumably, there are a range of decisions that can be made, but I do not know what it will be.

CHAIR: Are you able to give us on notice the full gamut of payments that are made to AMSs, or is that across departments?

Dr Bartlett: That is across departments. I assume we can pull it together, yes.

CHAIR: Thank you.

Senator SIEWERT: You have not looked at whether this will have an impact on the number of Aboriginal people actually going to visit the GP?

Dr Bartlett: We have talked since this session began about the difficulty of making estimates about individual behaviour. In an area like this, where we are really talking about amounts of money on the margins of the total amount of money that AMSs get, it is even harder to make estimates as to what likely behaviour is. I could not begin to do that.

Senator SIEWERT: Have you spoken to the AMSs about how this will impact on their services?

Dr Bartlett: I have not had representations from AMSs about the impact.

Senator SIEWERT: Has the department?

Dr Bartlett: I could not tell you. I would have to ask my Indigenous health colleagues.

Senator SIEWERT: Could you take that on notice?

Dr Bartlett: Yes.

Senator McLUCAS: This is also part of a conversation around AMSs. What support is the government going to provide to bulk-billing clinics, including AMSs, that do not have any transactional infrastructure?

Dr Bartlett: When we look at the data, currently 89 per cent of doctors bill at least some patients. And when you look at the 11 per cent that are left, there is another percentage of those doctors who work for corporate providers who charge patients. So there really are not that many doctors who do not have mechanisms in place to deal with charging patients; they have got it now.

Senator McLUCAS: Do we know how many there are?

Dr Bartlett: It is somewhere under 10 per cent of GPs now currently working.

Senator McLUCAS: And how many is that?

Dr Bartlett: I cannot give you that number off the top of my head, but I will see what I can find.

Prof. Halton: I would make the observation that it is not hard infrastructure to get.

Senator McLUCAS: No, but it is a cost of practice that this change will impose on up to 10 per cent of our doctors.

Prof. Halton: No, I do not think that is what is being said actually.

Dr Bartlett: The other thing with all of this is that we are talking GPs. You really have to talk practices. One of the difficulties for us is that we have a Medicare billing system that works in terms of GPs, but we have doctors who work in practices, and, part of what we will have to do, in terms of doing that, is work through the number of practices affected. But given the number of doctors who are billing, you would expect that the overwhelming majority of practices will have examples where they are billing. Even in areas with high bulk-billing rates, patient billing occurs.

Senator McLUCAS: It is not a large number but I dare say there are some and particularly I would dare say that lot of our AMSs would not have that infrastructure in place to facilitate charging a GP tax or a co-payment.

Dr Bartlett: There are clearly a series of consultations about implementation to occur that can address issues like this in specific circumstances where there are particular needs.

Senator SIEWERT: Of course this is on top of the other cuts that are being made to Aboriginal health?

Senator McLUCAS: That is right.

Dr Bartlett: Just as my colleagues could not talk about the MBS last Friday, I cannot talk about Indigenous health more broadly today.

Senator SIEWERT: I am just making the point that joining the two together will have greater impacts on AMSs than just this.

Senator Nash: If I can just clarify, I think the government is being very clear to say that the figures that you are referring to—the cuts, the savings—will be very much not front-line healthcare. I would not like us to be under the illusion that we are somehow weaving all those things in together for the point of discussion today. We have been very clear about reducing duplication, as you know, and more efficient administration in all of those type of things.

Senator SIEWERT: There is a $165.8 million coming out of Aboriginal health, which we established on Friday. You can talk all you like about front-line services—AMSs do not know what is happening to them after the next financial year.

Senator Nash: They are very well aware that there is a period of review, as you know. And just on that figure, that is if you only take it to 2015-16. If you take 2017-18 into account—because this is actually the end of forward estimates starting from 2014-15—there is $44 million going in. In actual fact, the figure is only $121 million. When you include last year and you drop off 2017-18, you get to 160, but to be clear and correct, the figure is $121 million.

Senator SIEWERT: By that time, you will have run the AMSs down. As for front-line services, that is what you said about legal aid.

Senator Nash: That is your view, Senator Siewert—

Senator SIEWERT: Go and talk to Aboriginal legal aid services.

Senator Nash: Running the AMSs down is in no way what this government is intending to do. For you to assert that is completely incorrect.

Senator SIEWERT: Go and talk to legal aid about front-line services and whether you are cutting those, because you are.

CHAIR: I do not think legal aid is very relevant because this is estimates.

Senator SIEWERT: Yes it is, because they make the same comment that front-line services will not be affected and they will be, the same as these services will be.

Senator Nash: There are gross generalisations, but we have been very clear that they will not be affected in relation to this matter.

Senator McLUCAS: I want to go to an example of someone who has stage 3b or more kidney disease. Let us use this particular patient as an example. I am advised that someone in this situation needs to see a GP every two months and a specialist every four months. Maybe Professor Baggoley will tell me if I am on the right track there.

Prof. Baggoley: I do not have that data.

Senator McLUCAS: Let us work on that basis. I am also advised that for specialist visits, someone in this situation would require the following tests: CBP, PTH, HbA1c, lipids test, urine, ACR, urine culture and iron studies. Which of those items would the tax apply to?

Dr Bartlett: The specialist or the GP requests all those tests as a lot. They will incur one co-payment.

Senator McLUCAS: Even if some are bloods and some urine. Which of these items would the tax apply to, and assuming someone had reached the Medicare safety net and was being charged the schedule fee, what would their out-of-pocket cost be?

Dr Bartlett: I could not begin to guess what their out of pocket costs will be. That will depend on the specialists they are seeing and a whole range of other things. It varies from case to case now; it will continue to vary from case to case.

Dr Bartlett: I could not begin to guess what their out-of-pocket cost would be. That will depend on the specialists they are seeing and a whole range of other things. It varies from case to case. Now it will continue to vary from case to case.

Senator McLUCAS: Do you do any analysis of what costs to individuals with certain presentations might look like?

Dr Bartlett: They are done a little. The reason I am saying they are done a little is because it is very hard to generalise about any patient journey, and when you mix that patient journey with the choices of individual doctors they interact with along that journey it becomes very hard to say anything meaningful about it. It is one of those areas where it is problematic for us.

Senator McLUCAS: You have not really done any work in trying to ascertain the cost for, say, a person with this kidney disease—or the many people with MS who have made contact with us and are concerned about this—in their ability to access the health services they need but also their health.

Dr Bartlett: The thing I would say about that is it is difficult to go through and come up with a meaningful figure, under the current arrangements, particularly given the variation in fees charged by specialists and things like that. This measure, to the extent it influences things for the person you talked about, is looking at potentially a $7 payment to the GP every two months and a $7 payment for that battery of tests that you described.

Senator McLUCAS: I do not have the frequency of that there. I have a letter here from a 36-year-old woman who has just been diagnosed with MS. She cannot work. We need to give these people some information about what is going to happen, how they are going to afford to manage their conditions. It is that chronically-ill group who are particularly concerned that this is going to mean the difference between going to the doctor or having a meal. You do not need to comment on that.

Saturday a week ago I was in Cairns with the easiest job I have ever done in my life—walking around with a 'Save Medicare' petition. It was, frankly, very easy. A pathology nurse raised a case with me: what about a person who is being monitored for their use of warfarin? She tells me that when a person is taking warfarin—some patients—they have to have a daily blood test.

Dr Bartlett: Again, what happens at the moment with people who have daily blood tests with warfarin—very significantly, some do it through their GP and it is bulk billed. Some do it through their pathology provider and they are charged a payment. That has been the case for some time and a number of people pay that.

Senator McLUCAS: She tells me that the patient she is particularly thinking of is bulk billed. If you have a fortnight of taking a daily blood test, you get to your 10 pretty quickly. But are you saying she would pay $7 every day?

Dr Bartlett: Yes.

Senator McLUCAS: She is not on a concession?

Dr Bartlett: She will continue to pay $7.

Senator McLUCAS: Indefinitely?

Dr Bartlett: Yes.

Senator SIEWERT: Until she cannot afford it any more.

Senator McLUCAS: Family-planning clinics operate in a not-dissimilar model to AMPs. Their doctors are usually salaried, is my understanding. Will women attending family-planning clinics be affected by the GP tax?

Dr Bartlett: It will depend on the items the doctors bill and it will depend on the model the clinic has in place. If they are using the standard GP consultation items then they will be affected. If they are using other items then they will not be.

Senator McLUCAS: A family planning clinic would use an item 23 fairly consistently and potentially other items that I do not know the numbers of. Has there been any analysis of what the impact would be, given there are a set of items that attract the tax, and how that would impact on the operations of a standard family planning clinic?

Dr Bartlett: No.

Senator McLUCAS: That is a shame. I now want to go to the impact on Headstart. Has there been any consideration given to granting exemptions to particular cohorts of people, particularly young people, who are attending a GP at a Headstart clinic? Headspace.

Prof. Halton: Headstart is for little babies.

Senator McLUCAS: I used to be a school teacher; that's right!

Dr Bartlett: It will depend very much on the range of items that they use and how they use them, and that will vary from clinic to clinic. There are better access to mental-health items that are not affected by this measure. There are chronic-disease items that are not affected by this measure. As I said, there will be a significant variation, but I cannot give you an overall picture for headspace clinics.

Senator McLUCAS: Is it true to say that most attendances at a headspace clinic would be for an item 23?

Dr Bartlett: I cannot tell you; I do not know.

CHAIR: Dr Bartlett, a number of the examples that Senator McLucas raised would cover people who would be considered to have chronic disease, would they not?

Dr Bartlett: They cover people who have chronic disease, but the proposed arrangement works on the basis of the item that is being charged rather than the condition of the person who is attending the doctor. So if you are getting a chronic disease management item, like a GP management plan, those items are not covered by this. But if as part of your management you are attending a GP from a normal consultation, that will be covered.

Senator CAROL BROWN: On 23 May, in *The Australian Financial Review*, Minister Dutton is quoted as saying that—claims by the patient advocates said the co-payment would deter many people from seeking medical help when necessary. He relied on his statement in the article, by Joanna Heath, on modelling from the Department of Health. Can you tell me what modelling the minister may have been referring to?

Dr Bartlett: As we said at the beginning of this session, we did an estimate and the minister indicated what that estimate is. It is an estimate.

Senator CAROL BROWN: He is talking specifically about modelling and you are talking about guessing.

Prof. Halton: We were not party to any discussions with journalists, so we cannot make any comment about that.

Senator CAROL BROWN: So the inference in this article that Minister Dutton was talking about, modelling that had been conducted by the Department of Health, is incorrect and he would only be talking about an estimate—briefs—that he had received from the department.

Prof. Halton: I think we have already figured out that there is a level of interchangeability in how those words are used sometimes. We have been very consistent with how we describe this, Senator. The reality is, we have estimates of this. That advice is very well understood.

Senator CAROL BROWN: It certainly seems to me that with this article—and I have not seen an article written to clarify what Mr Dutton meant by 'modelling'—we were all under the impression that some modelling had been done, till we got to estimates, where no modelling had been done. We have been guessing. Okay, I will put that to one side.

Senator McLUCAS: I would like now to move to the GP tax on rural and regional communities. Have you done any assessment of the different usage of the list of item numbers and how they are currently being used—the level of bulk billing et cetera—in regional and rural areas?

Dr Bartlett: We have not gone into it in that level of detail. We have taken a view about the way things work and then applied the estimation process that has been described.

Senator McLUCAS: Across the whole population, with the whole activity? So there has been no specific consideration. The reality is that it is quite different. Levels of bulk-billing in regional areas are very different, access issues are different and income levels are different.

Dr Bartlett: As I understand it, the levels of bulk-billing in regional areas are lower than the levels of bulk-billing in many metropolitan areas. The assumption is that the current billing arrangements that apply in regional

areas will continue to apply in regional areas. Doctors will make choice about whether they charge a patient and what they charge a patient. They will use, I assume, the same sorts of criteria they use now.

Senator McLUCAS: Minister, there was a lot of floating of the idea of a GP tax prior to the budget finally coming down. The Commission of Audit talked about $15. There was a conversation around $5 or $5.50. Did you go through a consultation process with rural and regional health stakeholders to canvas the notion of a GP tax with them?

Senator Nash: I was not privy to any discussion around the creation of the GP co-payment.

Senator McLUCAS: You did not consult with any regional health services or remote health services about, in a general sense, what it would mean for their services if you introduced this GP tax?

Senator Nash: There was speculation leading up to the announcement. I did not have any specific discussions on that matter.

Senator McLUCAS: You did not, as the minister responsible for regional and rural health, provide any advice into the process at all?

Senator Nash: No.

Senator McLUCAS: Have you asked for any modelling to be done on the impact of the GP tax on accessing primary care in regional Australia?

Senator Nash: Matters around the co-payment are for the senior minister to determine.

Senator McLUCAS: So you do not do any work on how it impacts on regional and rural health?

Senator Nash: I am not in a position to request the department to do modelling on an area as it relates to funding arrangements.

Senator McLUCAS: You are not allowed to?

Senator Nash: I did not say I was not allowed to; I said it was a matter for the senior minister.

Senator McLUCAS: Has he requested any analysis be done on what this will mean for regional and rural health?

Senator Nash: That would be a question for Minister Dutton.

Senator McLUCAS: You will ask him? You are, after all, representing him here.

Senator Nash: I can certainly take that on notice.

Senator McLUCAS: That would be very helpful. We know that there are poorer health outcomes in rural and regional areas now. Has any work been done to try to ascertain what this might mean for health outcomes. Not the budget, not what happens in a doctor's surgery—what will happen with respect to the fact that you are sicker and poorer if you live in the country?

Senator Nash: The government is addressing this in a range of ways. You would have seen the measures we announced during the election campaign: infrastructure grants for regional GPs, increasing the training payment, having extra scholarships for nursing and allied health. There are a range of measures which clearly demonstrate that we understand the differential between metropolitan and regional areas. The best thing we can do for regional areas is fix the economic mess that the previous Labor government left us. In the area of health provision, I have alluded to some of the programs that we have started as part of this budget process.

Senator McLUCAS: But, if you do not go to the doctor, you do not get fixed; you do not get diagnosed. How many times do regional Australians visit the GP per year on average? Maybe Dr Bartlett can help us here.

Dr Bartlett: I will have to take that on notice. I am sorry but I do not have the number with me.

Senator McLUCAS: But it is something you can—

Dr Bartlett: It is a number I can get for you.

Senator O'NEILL: My question goes to a scenario where a young person finds themselves unemployed and has a six-month period without income and requires the attention of a doctor. Can you explain to me how this new GP tax works when they show up with their Medicare card?

Dr Bartlett: Again, that will be between them and their doctor. I cannot explain how it will work in an individual case.

Senator O'NEILL: So if somebody presents and they are sick—and the doctors have presumably taken their Hippocratic Oath and they have a duty of care—what can doctors practically do when confronted by significant numbers of young unemployed people seeking their assistance and no capacity to pay?

Dr Bartlett: They will have a range of choices available to them, as they do now.

Senator O'NEILL: Turned away being one option, I suppose.

Dr Bartlett: As it is now, Senator.

Senator O'NEILL: Or absorb the cost. That is another option.

Prof. Halton: I think we need to be a little cautious here. We cannot make any comment in an area where you are going to how many young people may or may not be eligible for any kind of concession card based on what will happen to their status—that is a question for another portfolio. I am happy to take on notice an inquiry into the other portfolio that might enable us to answer the question, but the suggestion which is implicit in what you are asking is that all of those young people would be ineligible to be concessional patients. We do not know that; we do not have that information. I am happy to take that on notice and we will give you an answer.

Senator O'NEILL: There is obviously going to be an intersection point between the government's policy about young people who find themselves unemployed and having no money for six months and their health needs. They certainly will not avoid becoming unwell for a period of six months because they cannot afford it. The reality is that health needs will need to be met. There will be, amongst that group of people, young people who are chronically ill—some of them might even be on warfarin and have to pay $7 every day. What I am going to ask you to do is provide a detailed policy outline on what is going to happen to those young people. When these two government policies intersect, what modelling or estimates can you make about how young people who are unemployed and sick are going to negotiate the new coalition model of healthcare for Australia?

Dr Bartlett: The one thing that I can say in terms of that is that, when we look at usage of health services and GP services, 20-29 year olds are among the lowest users of health services across the community.

Senator O'NEILL: Well, is it not lucky that they get less sick less often. If you are chronically sick and unemployed and you are young, it sounds like this government has no plan for you. Good luck.

Senator PERIS: You would have heard of the Centre for Remote Health.

Dr Bartlett: I have heard of it.

Senator PERIS: Have you seen their recent research paper that they have put into the Medical Journal of Australia?

Dr Bartlett: No, Senator.

Senator PERIS: The content of it was that the paper found that not only do lower rates of primary healthcare lead to higher rates of hospitalisation, lower mortality rates and lower life expectancy, the paper was actually about the cost effectiveness of primary care for Indigenous Australians with diabetes living in remote Northern Territory. The paper also concluded that there are significant savings and better health outcomes for patients with diabetes when access to primary care is improved. In fact, they actually came up with a figure that investing $1 in primary healthcare for people with diabetes in remote Indigenous communities could save $12.90 in hospitalisation costs. My question is whether you can explain how the copayment will improve this situation, given the impact that it is going to have?

Prof. Halton: We have not seen that report, so we cannot comment on it.

Senator PERIS: Would you like a copy?

Prof. Halton: Not now, because we cannot sit and read and digest it to comment on it.

CHAIR: Senator Peris, if you would like to provide it to the department I am sure they will do their best to respond to it as promptly as possible.

Senator PERIS: Maybe I will give it over and ask that question later on.

CHAIR: Okay. Perhaps we will take this opportunity to go for a break until 4.15 pm.

Proceedings suspended from 15:59 to 16:15

CHAIR: We are ready to get going. We are going to program 3.5 and program 3.6, but, in the interim, the document that Senator Peris was referring to has been provided. Given that it is a public document, as I understand it, we do not have to formally table it as a committee, because it is available. But, given its density, perhaps your questions are going to have to go on notice, Senator Peris, because we cannot expect the officials to absorb it in the next 10 minutes or so and respond.

Senator PERIS: Given the significance and importance of what we are talking about here, will the department be taking into consideration research documents like this to see how much of an impact the GP co-payment is going to have on GPs in the delivery of remote services for chronic illnesses?

Dr Bartlett: As we said during the earlier discussion about AMSs and AMS funding, the impact of this measure on them is limited and there is an opportunity, obviously, with consultation about implementation, to look at how that impact can be managed—ad that will be done.

Senator PERIS: So there will be further consultation done? Is that what you said?

Dr Bartlett: There is a process of consultation with all of the affected clinical groups and subgroups as part of implementing these measures. So, yes, that will absolutely be done.

Senator PERIS: Okay. Thank you.

Senator SIEWERT: I want to ask about the potential sale of Australian Hearing. Is this the right place to ask it?

Dr Bartlett: No. There are two places you can potentially ask about that. One is the Department of Human Services estimates, given they are the department responsible for Australian Hearing. The second is the Department of Finance, who are responsible for—

Prof. Halton: Selling, if necessary, anything.

Senator SIEWERT: Okay. I will be talking to Human Services, but maybe there are some issues that you can answer for me in terms of the potential impact of the sale of Australian Hearing on the provision of services to those with a hearing impairment. Has the department been consulted about it? Were you involved in any discussions around the potential sale of Australian Hearing?

Dr Bartlett: There has been a very initial discussion. As I understand it, the Department of Finance is looking at doing a scoping study, and we will be involved in that as it happens.

Senator SIEWERT: Did you have any discussions before the department made a decision to carry out a scoping study on its potential sale?

Dr Bartlett: Not directly, no.

Senator SIEWERT: You have not been. So the department's opinion or advice on the impact it could have was not sought?

Dr Bartlett: The thing I would have to say with all of this is that there are essentially two parts of the hearing services arrangement. There are the voucher arrangements, and there is the community service obligation. Those continue. Obviously, there is a discussion that needs to happen and will happen as part of any scoping study about the sale. But it is separate.

Senator SIEWERT: Has your opinion or advice been sought on the potential of expanding the voucher service to cover the services that are being provided by Australian Hearing to younger people with hearing impairment?

Dr Bartlett: Are you talking about covering the 28 to 65—

Senator SIEWERT: No, but say what you were going to say and then I will ask another question.

Dr Bartlett: There was a discussion about 28- to 65-year-olds as part of the Senate inquiry that was done, but nothing specifically related to this.

Senator SIEWERT: That is not what I am talking about. If Australian Hearing is sold, with the services it provides to younger Australians, there then obviously needs to be a way of providing that service and support to younger Australians until the age of 26. Those services are going to have to be provided. One of the options that I know the community are thinking about is that the government might decide to go to a voucher system for those Australians as well. Have you been consulted about that?

Dr Bartlett: Not as yet.

Senator SIEWERT: So there has been no consultation with the department and no canvassing of what it would mean for you to expand the voucher system or scheme?

Dr Bartlett: Not as yet.

Senator SIEWERT: Have you been involved in any discussions over terms of reference for the potential scoping study?

Dr Bartlett: I have seen a draft, that is all, but I have not been involved in discussions about them. We have been provided a draft. The process is being run by the Department of Finance and you need to ask them about terms of reference and things like that.

Senator SIEWERT: You have seen a draft. Was that by accident? Were you shown that? Did you comment? It seems strange that you have seen a copy of a draft and then were not asked to comment on it.

Dr Bartlett: We were provided a draft of the terms of reference by the Department of Finance, who want us involved in the scoping study.

Senator SIEWERT: Sorry, they want you to be involved?

Dr Bartlett: The Department of Finance want the department and the Office of Hearing Services involved in the scoping study.

Senator SIEWERT: That is what I am trying to find out. Did you then comment on those terms of reference?

Dr Bartlett: We have not commented as yet.

Senator SIEWERT: Will you comment on those terms of reference?

Dr Bartlett: I have to say that they have not been front of mind for me over the last period of time, so I could not tell you as yet.

Prof. Halton: I am sure, if they require commentary, you can be absolutely guaranteed we will comment.

Senator SIEWERT: Why wouldn't they require comment on the selling of Australian Hearing? I presume you are aware this is a significant issue for the community.

Prof. Halton: The point is this: if we believe the draft that has been provided to us is inadequate in canvassing the issues for which we are responsible, we will tell them so.

Senator SIEWERT: Do you believe they are inadequate?

Prof. Halton: I have not seen them.

Dr Bartlett: And I have not looked at them thoroughly enough to comment.

Senator SIEWERT: Do you have a time line for which you have been asked to comment and get your comments back?

Dr Bartlett: I am sure I have, but off the top of my head I cannot tell you what it is.

Senator SIEWERT: Would you take it on notice, please, to provide what that time line is? Thank you. Have you been asked to provide any comment on the sale of Australian Hearing and how it will impact on hearing impaired children and their families, beyond the terms of reference?

Dr Bartlett: No.

Senator SIEWERT: Are you aware of any consultation that has been undertaken with the community about the potential sale of Australian Hearing?

Dr Bartlett: Again, I think you are asking a question that you probably should ask the Department of Human Services or Australian Hearing themselves.

Senator SIEWERT: I will, obviously, be asking Australian Hearing that question. Regarding the CSO, are you investigating the contestability of CSO services?

Dr Bartlett: Not at this stage.

Senator SIEWERT: Do you plan to?

Dr Bartlett: That is not my decision; that is a decision of government.

Senator SIEWERT: Does the government plan to? Are you aware of any plans to? Have you been asked to look at that?

Dr Bartlett: I am not aware of anything at this stage.

Senator SIEWERT: Minister, are there any plans to look at the contestability of CSO services?

Senator Nash: Not that I am aware of, but I am happy to take that on notice.

Senator SIEWERT: Would you take that on notice. Thank you.

[16:24]

CHAIR: We will move on to dental services forthwith.

Senator DI NATALE: I just wanted to clarify: we have $229 million over four years which has been taken out of the dental Flexible Grants Program and the deferral of the National Partnership Agreement for adult public dental services is $390 million. Is that correct?

Ms Flanagan: That is correct.

Senator DI NATALE: Given that the indicators for oral health are still very poor, what was the rationale for taking $600 million out of dental health rather than another area?

Ms Flanagan: To characterise it in that way is not quite right. First of all, the national partnership agreement, the dental partnership agreement, has been deferred by a year. The reason for doing that is that there is a national partnership agreement that we have with the states and territories to deliver dental services on foot at the moment. That finishes at the end of 2014-15. So, in fact, there was going to be an overlap between the current partnership agreement and the new partnership agreement. So the new partnership agreement has merely been deferred by one year. I do not know whether my colleagues want to add to that?

Senator DI NATALE: But that is $390 million— that should have been spent and was budgeted to be spent in this financial year—that is not going to be spent.

Ms Flanagan: It has been pushed out a year.

Senator DI NATALE: And that is not a cut? To my mind, that represents services that would have been provided in that financial year which will no longer be provided.

Ms Flanagan: In a particular financial year, yes. But, in terms of the total spend, it has been pushed out a year. One of the reasons for doing that is, as I said, that the current partnership agreement is still in operation. There will still be about $110 million spent in 2014 15 for the delivery of public dental services. It was going to, I think, more than double—much more than double—and there was a concern about the capacity of the public dental system. So there has been some smoothing of the dental funding to be provided to states and territories.

Senator DI NATALE: But those services could have been provided through vouchers in the private system, could they not?

Ms Flanagan: They very possibly could have been, but the other thing that has just started, as you would know, Senator, is the Child Dental Benefits Schedule. That started in January. We were just wanting to ensure that the money would be well spent and that we did not overload the system.

Senator DI NATALE: I do not want to labour this point, but there is $390 million that would have been spent in the financial year. It is now not going to be spent. People are not getting those services in that financial year. There is a capacity to provide those within the private system.

Ms Flanagan: That is a matter for conjecture.

Senator DI NATALE: Are you saying that the reason for not spending the $390 million in the financial year, and deferring by a year, is simply because of capacity—nothing to do with any budgetary considerations?

Ms Flanagan: The policy rationale for this was certainly a concern about whether the system had the capacity to deliver that many services in a year. There is no cut to the funding. This is about smoothing.

Senator DI NATALE: Deferring funding by a year—I would like to use that rationale with my bank, with the loan I have on the house. 'I am not going to pay the loan three-year. I am not defaulting on the loan; I am just not going to pay it for a year.' Come on.

Ms Flanagan: I am sure your bank would allow you to change your mortgage repayments.

Senator DI NATALE: Maybe I am with the wrong bank. How does that translate in terms of number of services—the $390 million?

Mr Maskell-Knight: We estimated that the total number of services to be provided under that national partnership agreement would be about 1.4 million.

CHAIR: Under both?

Mr Maskell-Knight: Under the second national partnership agreement.

CHAIR: The adult services?

Mr Maskell-Knight: Yes. So we estimated that $1.3 billion would get you 1.4 million services. Calculating it back out on a pro rata basis, there will be that number. But I have not done those maths yet.

Senator DI NATALE: It is about a third or so, roughly.

Mr Maskell-Knight: It is about a third.

CHAIR: I have a clarification question. We have talked about the capacity issue. How did the department go about assessing the capacity of the states to deliver on two partnerships at the same time?

Mr Maskell-Knight: We have been in discussions with the states about their ability to deliver under the first national partnership agreement and their ability to provide services to children under the Child Dental Benefits Schedule. I think it is fair to say that states have got different levels of capacity. Some states have found it easier to provide services through vouchers than others. Some of the smaller states, in particular, I think are struggling with the relatively constrained private sector and the private sector's lack of interest in providing services on

behalf of the state government. The other factor which Ms Flanagan alluded to is the Child Dental Benefits Schedule is going to be taking up the attention of many private sector dentists.

CHAIR: Could you expand on what you mean by that?

Mr Maskell-Knight: We estimate about $600 million worth of dental services are going to be provided under the Child Dental Benefits Schedule per year. That will require private sector providers to provide those services. In conjunction with their regular work, if you like, that erodes their capacity to provide public sector services on behalf of the state dental services.

CHAIR: Can you clarify how much money the states would have received in the 2014-15 year if both agreements had continued on?

Mr Maskell-Knight: $319 million.

Senator DI NATALE: To continue on with that point and to perhaps expand on it, obviously if the state dental service cannot provide the service, they have the capacity to give a patient a voucher. That patient takes that voucher to a private dentist and can have the service done at the private dentist. That is what we are talking about when we are talking about vouchers.

Mr Maskell-Knight: Yes.

Senator DI NATALE: What is the capacity constraint there? Are you suggesting that, at the moment, vouchers are being given to patients and those vouchers are not being honoured by private dentists? My understanding is that there are a number of private dentists who are at the moment working below capacity and would welcome the opportunity to do some public work. Have you got any evidence of that and, if so, could you provide that to the committee?

Mr Maskell-Knight: The smaller jurisdictions have told us that that is not the case for them and that the private sector, particularly in Tasmania, the territories and to some extent Western Australia, is reasonably constrained.

Senator DI NATALE: But they are small jurisdictions. With respect, in New South Wales and Victoria where the bulk of the services are going to be delivered there is a capacity within the private dental providers to deliver those services. Why would you not at least make the funding available in those states if it is really just a question of capacity?

Mr Maskell-Knight: I think it is a national partnership agreement. We would like to treat everywhere equally. Having said it is a particular problem in the smaller states, I think that the Child Dental Benefits Schedule is yet to make its full effect apparent in the private sector.

Senator DI NATALE: So you are having a guess that maybe it the implementation of the Child Dental Benefits Schedule that is going to impose some capacity constraints on the system. Why not make the funding available and if it is not utilised then nothing is lost? At the moment people are being denied access to important dental services.

Mr Maskell-Knight: I think it eventually goes to a decision of government that, having regard to the factors that we have put before them, this government made a decision to defer for 12 months.

Senator DI NATALE: I just want to ask a couple of question on the Child Dental Benefits Schedule. Do you anticipate any changes to the schedule as a result of any changes to the family tax benefit arrangements?

Mr Maskell-Knight: No.

Senator DI NATALE: Sorry, I meant changes to the program in terms of eligibility.

Mr Maskell-Knight: Eligibility hangs off the family tax benefit arrangements. If they change, then eligibility for the Child Dental Benefit Schedule changes.

Senator DI NATALE: Is there a model of that?

Mr Maskell-Knight: I do not know if that is the right word, but certainly insofar as there are impacts on the number of people estimated to be eligible for FTB part A, that will flow through into estimates for spending under the Child Dental Benefits Schedule.

Senator DI NATALE: I beg the indulgence of the chair. I have a question for clarification from the previous session. It was the issue of the one per cent change in growth as a result of the co-payment. I just wanted to clarify the figures. You were saying there were 120 million GP visits on average per year. I was not sure if that one per cent related to the total figure or to the change in growth.

Dr Bartlett: What it relates to is that at the moment GP services are growing by about 4.7 per cent per year. It is anticipated, or estimated, that they will grow by 3.7 per cent.

Senator DI NATALE: So that is four per cent of that 120 million visits.

Dr Bartlett: I would have to go back and confirm for you the actual number of GP services.

Senator DI NATALE: But it is one per cent of the total, not the difference in growth.

Prof. Halton: That is right.

Senator DI NATALE: That is all I wanted.

Senator SESELJA: There has been a lot of discussion about the co-payments for the Pharmaceutical Benefits Scheme. I just wanted to go back and ask—under the previous government, between 2008 and 2013, did anyone in the department ever suggest, discuss or propose an increase to co-payments in the Pharmaceutical Benefits Scheme?

Prof. Halton: Sadly, those offices are not actually here any longer, Senator.

Senator SESELJA: Neither yourself nor Dr Bartlett—

Prof. Halton: Dr Bartlett cannot answer those questions.

Senator SESELJA: You do not have any knowledge of that?

Prof. Halton: I do not have the detail with me. I am happy to take it on notice.

Senator SESELJA: The question was whether there was ever any proposal under the previous government, between 2008 and 2013, to increase co-payments in the Pharmaceutical Benefits Scheme?

Prof. Halton: I am not sure whether we are even allowed to answer that question. We would have to take some advice.

Senator SESELJA: Likewise, did anyone ever approach the department during that period discussing the idea of a co-payment for GP visits?

Prof. Halton: We will take it on notice.

Senator SESELJA: In taking that on notice, could you also let us know whether there was any approach from other departments, such as PM&C, or, indeed, from the Minister's office or the Prime Minister's office.

Prof. Halton: We do not receive approaches from prime ministers' offices. We do not have dealings with them.

Senator SESELJA: Presumably, if it did, it would come through Prime Minister & Cabinet.

Prof. Halton: Yes, and if we have records and if we are able to answer the question, we will come back to you.

Senator SESELJA: That would be great. Any other detail you are able to provide around that, on notice, would be great.

Senator McLUCAS: Dr Bartlett, we were talking about the number of concession card holders and their frequency of attendance at a GP—that is all concession card holders. Can you disaggregate that amount to take out the over 65s? What is the frequency of visits to a GP for a person over the age of 16 and under the age of 65? Is that a reasonable question?

Dr Bartlett: It is a reasonable question. I do not know whether we have a straightforward answer. I know we can disaggregate it by pension card type. My understanding is they include a range of pensions within a pension card type. So whether we can then subdivide it—I know that the single highest users are Pension Concession Card holders, the next highest are the Commonwealth Seniors Health Card holders, and the others are considerably lower than those. But age break-ups within those—I do not know what we can do or how quickly, but we can certainly take it on notice.

Senator McLUCAS: When we aggregate all of the concession card holders, the largest group of users of GP services are people over the age of 65.

Dr Bartlett: I believe so.

Senator McLUCAS: I am just trying to work out what the frequency of visits is for those people under the age of 65. I think it is probably sensible to cut out the under-16s as well, but I do not know if you can do that.

Dr Bartlett: I will see what we can do.

Senator McLUCAS: Budget paper no.2 on page 132 talks about market testing on the payment of health services by commercial payment service providers, and $500,000 has been allocated next year. Can I get an understanding of what is proposed? What is the scope of that?

Dr Bartlett: It is essentially an initial look at whether or not there is an alternative way in which the MBS and PBS payments can be made.

Senator McLUCAS: At what point in the process? Are we saying that Medicare is not going to do it anymore?

Dr Bartlett: The budget measure itself said that the government believed it was appropriate to begin a process of reviewing whether there were alternatives.

Senator McLUCAS: Alternatives to the payment of the rebate to the patient?

Prof. Halton: No, to the mechanisms—as in how and who makes those payments.

Senator McLUCAS: Can you elaborate please.

Prof. Halton: Medicare Australia currently has that responsibility. You will remember, given some of your previous responsibilities, that some of the computers are somewhat antiquated—brown paper and string would not be an unreasonable description in some respects—so the question is about whether or not those payment functions should be put to market to test the cost of doing that and how it might be best delivered as a service. It is not a question of what moneys—that is a separate issue.

Senator McLUCAS: I will ask some follow up questions on notice about that. Can I go to optometry briefly? At the moment, Dr Bartlett, I understand all optometrist services are bulk billed in Australia. Is that correct?

Dr Bartlett: Most optometrist services are bulk billed.

Senator McLUCAS: The standard eye test is. Is that correct?

Dr Bartlett: What happens is that optometrists can bill up to the schedule fee. So there is bulk billing at 85 per cent, and then they have got a range up to 100 per cent, but the overwhelming majority—well over 90 per cent—are bulk billed.

Senator McLUCAS: What is the policy rationale to reduce optometry rebates and also allow optometrists to set their own fees?

Dr Bartlett: The optometrists, for an extended period of time, have essentially been saying that the undertaking that they gave to get into the MBS constrained them in a way that no other provider group was constrained. The rationale of this is to essentially normalise it.

Senator McLUCAS: So the government caved in. Is that the answer?

Dr Bartlett: That is your characterisation, Senator.

Senator McLUCAS: We know that they have been trying to get out of their responsibilities.

CHAIR: You would have been a little bit surprised if the official had answered that question, would you not, Senator McLucas?

Senator McLUCAS: What was the consultation that was undertaken in taking the decision? That is possibly a question for the minister.

Senator Nash: Sorry, which part of the decision?

Senator McLUCAS: To reduce the optometry rebates and allow for optometrists to set their own fees.

Senator Nash: That is a decision made in the budget context.

Senator McLUCAS: I asked about the consultation. Did you meet with the optometrists?

Senator Nash: I am not aware, sorry. I am not privy to that.

Dr Bartlett: There was a lengthy dialogue with the optometry sector about some of their concerns in this area.

Prof. Halton: Over a long number of years.

Senator McLUCAS: Do you have any understanding of what impact this uncapped fee change is likely to have on patient access to eye care?

Dr Bartlett: It is not expected to have an impact on patient access to eye care. At the moment, optometrists have a choice as to what they bill. Overwhelmingly they are choosing to bulk bill. There are a range of economic drivers within that sector, and it is believed that those economic drivers will ensure that a similar sort of thing continues.

Senator McLUCAS: Have you done any assessment on what the growth in fees for optometry services will be to the patient?

Dr Bartlett: Again, we think that there are a range of interactions going on in that sector at the moment. A number of suppliers use optometry services as a way of getting people to buy spectacles and spectacle frames. The assumption is that that sort of interaction will continue as it does now.

Senator McLUCAS: I have got a lot of bits that will come on notice, but let us go to the Medicare safety net. Can you give me an understanding of how the cut of $270 million will be affected by these budget measures?

Dr Bartlett: We currently have three Medicare safety nets. There is the greatest permissible gap which, essentially, says that the 85 per cent scheduled fee is restricted to being no more than I think $76.20. That amount is indexed each year. There is the original Medicare safety net that means that once you reach a threshold of around about $470, you then get the gap between 85 per cent and 100 per cent made up, and that is paid. Then there is the Extended Medicare Safety Net where the government, once you have reached a threshold—it varies for concessionals and general patients—will then pick up 80 per cent of the gap that you are charged. However, that is not unqualified; there are a series of items that are capped which means that the government's contribution is capped as well. There were a range of changes made over the last few years, initially, in particular to deal with ART and obstetrics and then extended to cover a range of other areas where there was evidence of significant billing increases.

I do not have the exact thresholds with me, but the Extended Medicare Safety Net concessional threshold is around about $660 from 1 January next year, subject to the passage of legislation; the Extended Medicare Safety Net general threshold will be $2,000; and, under the single safety net, what happens is that all those three are rolled into a single safety net. Under that single safety net there are significantly lower thresholds and so for concessional singles and families the threshold is $400, for FTBA families and general individuals it is $700 and for general families it is $1,000. Essentially, as you get toward those thresholds the government will recognise up to 150 per cent of the scheduled fee, and that is added towards getting to the threshold. Once you are over the threshold, the government will pay 80 per cent of the gap up to 150 per cent of the scheduled fee.

The save comes because there are certain areas where there are very high fees charged, and the 150 per cent of the scheduled fee cap means that those will no longer be covered in the same way. But what happens through this is that a significant number of extra people get access to the safety net, and so more people will be getting covered by the safety net—but a number will get covered for a significantly smaller amount.

Senator McLUCAS: Will the thresholds for access change with the MBS safety net over time?

Dr Bartlett: I am assuming that they will be indexed because we typically index—

Senator McLUCAS: Just indexed?

Dr Bartlett: Just as we index safety net thresholds now.

Senator McLUCAS: I might go and read the *Hansard* about that. Has the department been asked to work up any proposals for the notion of refinement? There is consideration in the media today, particularly from the AMA, that there might be some refinement particularly to the co-payment. I am not asking what the minister might have asked of you, but has the department been asked to work up any proposals around the question of refinement?

Dr Bartlett: As I said earlier in answer to some other questions, as part of the process moving towards implementation of this measure there will be consultation with the sector to work through potential issues about implementation. That is the work as I understand it.

Senator McLUCAS: I do not think that you understand my question.

Dr Bartlett: I may not be—

Senator McLUCAS: What I am asking you is: has the minister, or the minister's office, requested the department to work up any options for what the Prime Minister is talking about? And that is refinement, particularly around the Medicare co-payment or GP tax.

Prof. Halton: It is fair to say that we have all manner of information about all manner of options available to us as we speak. Whether that predates or postdates the budget is immaterial. We actually can answer, even now, a whole series of questions if they are put to us.

Senator McLUCAS: Does that go to the issue of the modelling that Dr Bartlett was talking about earlier?

Prof. Halton: The estimation.

Senator McLUCAS: The estimation. So if the Prime Minister said, 'Okay, let's cut to $6', you could spit out an answer about what that means for access or what that means for—

Prof. Halton: That is a fair assumption.

Senator McLUCAS: Senator Brown was pursuing the question of what is modelling and what is figuring. We tried to work that through—

Prof. Halton: And what is our arithmetic, yes.

Senator McLUCAS: Senator Brown, what is the name of that modelling system that Treasury uses?

Senator CAROL BROWN: PRISMOD.

CHAIR: Is this the last question?

Prof. Halton: There are a number of models. The NATSEM model is an example. There are a number of big models around. We do not use any of those.

Senator McLUCAS: Okay. That is the question that I wanted to know the answer to.

Dr Bartlett: Sorry, Senator, I should say—I missed it—the EMSN concessional threshold is $624.10. That was the number that I did not have.

Senator McLUCAS: I will read the *Hansard*, because I was trying to get a lot done in a short amount of time. We might come back to you.

Senator SMITH: Of course refinement is not a new thing. I might just read from the House of Representatives *Hansard* from 3 September 1991 when Bob Hawke was talking about refinement on their Medicare co-payment proposal. Mr Hawke says:

The fact is that we have addressed in the Budget a very important issue in regard to Medicare.

That is the Medicare co-payment introduction. He continues:

It is one which, understandably, has raised concerns and issues in the minds of not only members of my Party but also groups in the community who are entitled to have a real interest in this matter. We are going to provide the opportunity for members of the Caucus who, over the years of this Government, have had a very substantial and constructive input into the decisions of this government. We are going to provide them with the opportunity to make what I am sure will be positive and constructive contributions.

So refinement is not a new feature. A co-payment proposition is not a new idea. It was introduced not only as an idea but it was a budget measure and it was legislated for in 1991 under the Hawke government. I am curious to know what conversations the Department of Health might have had in the period 2008 to 2013 in regard to a GP co-payment.

Prof. Halton: I think this is very similar to the question that your colleague next to you asked earlier, and I said we will have to take that on notice.

Senator SMITH: Why?

Prof. Halton: (1) I am unclear as to whether we can actually answer the specifics of that question and (2) I do not think we can answer it right now in any event, even if we can.

Senator SMITH: Let me be more specific. Have you had any approaches from the Department of Finance or the Treasury over the past six years in regards to a GP co-payment. Because any—

Prof. Halton: My earlier answer applies.

Senator SMITH: What was your earlier answer?

Prof. Halton: (1) I am not sure whether we are actually permitted to answer that question, and we will have to take some advice, and (2) we do not have that information available to us. We get asked for all sorts of things all of the time, and, quite frankly, going back to the dates that you have indicated I do not think that any of us can remember. We will have to check.

Senator SMITH: 2008 to 2013? Last year?

Prof. Halton: Correct. And it is fair to say that we would deal with probably amounting to hundreds of options in budget processes and, more broadly, over the course of that period.

Senator SMITH: I suspect that not all budget proposal ideas are the same in terms of the level of interest that they might attract internally or, indeed, politically. How long would it take to get the advice about whether or not you could reveal to this committee about whether or not Treasury and/or Finance had approached the Department of Health about GP co-payments in the period 2008 to 2013?

Prof. Halton: I do not know the answer to that. We will make inquiries in an expeditious way, in terms of the propriety of the question. You will understand that we do not wish to create a precedent. So the question of whether we can answer, we will check and come back to you as soon as we have had some advice. We will have

to go to the elders and central departments. But in terms of what we have been asked in relation to the past, I do not know how long it would take us to find that out.

Senator SMITH: Just to be clear, in order to find out whether or not you can actually advise this committee about whether or not you can answer that question, you will need to go to Treasury and Finance?

Prof. Halton: No, Prime Minister and Cabinet.

Senator SMITH: My next question goes to the issue of the Department of Prime Minister and Cabinet. I am curious to know whether Mr Watt has at any time raised with you the proposal of a GP co-payment.

Prof. Halton: Dr Watt.

Senator SMITH: Dr Watt, the Secretary of the Department of Prime Minister and Cabinet.

Prof. Halton: As in, was he party to discussions in relation to this matter?

Senator SMITH: No, has he come to you with a proposal in regard to a GP co-payment.

Prof. Halton: Has he personally come forward—

Senator SMITH: Has he, in his capacity as Secretary of the Department of Prime Minister and Cabinet, spoken to you, in your capacity as the Secretary of the Department of Health, about a GP co-payment proposal?

Prof. Halton: In a broad context, he has raised the issue in a discussion amongst—it is very hard to answer that question. Bilaterally approached, no.

Senator SMITH: Could you explain that, 'bilaterally approached, no' as opposed to unilaterally?

Prof. Halton: Has he approached me one-on-one in relation to that matter, no.

Senator SMITH: Have you been in discussions with other people, and Dr Watt, in regard to a GP co-payment?

Prof. Halton: Senator, it is no secret that the budget decision-making process involves a range of ministers, as members of the Expenditure Review Committee, and their relevant officials and their relevant advisers. It is fair to say that the Prime Minister and the head of his department are both party to Expenditure Review Committee discussions and decisions. It is fair to say that Dr Watt was party to those discussions.

Senator SMITH: So has a GP co-payment been an issue under consideration by the Expenditure Review Committee in the period 2008 to 2013?

Prof. Halton: My earlier answer applies. I can only talk about the process we have just been through. We will have to go back and look, in relation to the other issue.

Senator SMITH: Secretary, with all due respect, I do not think that is a defensible response. An issue of an GP co-payment, if it had been under consideration in the period 2008 to 2013, I am very confident that you would recall that.

Prof. Halton: Your confidence is very welcome, but I cannot answer the question until I have taken broader advice.

Senator SMITH: How long will it take to get that broader advice?

Prof. Halton: I do not know. We will go to the Department of Prime Minister and Cabinet and find out.

Senator SMITH: I will put it another way. You cannot rule out that a GP co-payment was discussed in the period 2008 to 2013.

Prof. Halton: Senator, I am saying to you I will take advice on whether the question can be answered. You cannot impute from that I am either ruling anything in or out. That is not reasonable.

Senator SMITH: The issue of sustainability around health funding and Medicare is not a new issue. It is not a new issue to this government; it is not a new issue to previous governments. I am keen to explore what nature of proposals might have been discussed as a way of introducing or maintaining some stability into the Commonwealth's health-funding budgets. I am keen to understand whether a GP co-payment had been an issue of consideration. I am keen to understand whether Dr Watt raised the proposal with you, in his capacity as Secretary of the Department of Prime Minister and Cabinet.

Prof. Halton: And I will take advice, Senator.

Senator SMITH: And you will be able to get back to us in an 'expeditious' manner, I think was your word.

Prof. Halton: If the answer comes back expeditiously we will seek it expeditiously, but if I do not get it expeditiously I will not be able to come back to you. If we get it expeditiously we will certainly come back and advise.

Senator SMITH: That would be great.

Senator SESELJA: When you do take that on notice, Secretary, would it be possible—if the advice is that you can answer the question and it was proposed or discussed during 2008 to 2013—for you also to come back with what figure was suggested as a proposed GP visit co-payment during that period?

Prof. Halton: We are getting into hypotheticals. Let's find out whether we can provide any advice practically first and then we will see what it is we have.

Senator McLUCAS: Did the Labor Party in government introduce a GP co-payment?

Senator SESELJA: In 1991.

CHAIR: Under the Hawke government.

Senator McLUCAS: In 2008 to 2013.

Prof. Halton: Under the Rudd-Gillard-Rudd government, no.

[17:00]

CHAIR: We are now moving to outcome 5: primary health care. Let's see how long it takes us to get through the programs. I think they might be quite quick. Then we will move on to the National Mental Health Commission, Medicare Locals and GP Super Clinics.

Senator McLUCAS: It would be sensible and logical to do 5.1—primary care financing, quality and access—and then Medicare Locals and GP Super Clinics.

CHAIR: That is the intention.

Senator McLUCAS: The review of Medicare Locals was dated on 4 March. When was that review provided to the minister?

Prof. Baggoley: That review would have been provided around about 4 March.

Senator McLUCAS: It was published basically the day it was received.

Prof. Baggoley: Yes.

Senator McLUCAS: Will the government be responding to the Horvath review in that sort of a formal respond to a document way?

Prof. Baggoley: The minister has already indicated that he accepts the recommendations of the review.

Senator McLUCAS: The recommendations go to a range of elements. Let's go to the number of Medicare Locals that are expected to change and the timetable over which that will occur. Could you provide the committee with some information about the number?

Prof. Baggoley: Certainly. There has not been a decision on the exact number as of yet. There has been an indication that the number would reduce from the current 61 to a much smaller number of primary health networks. Those primary health networks would have boundaries that would align with local hospital networks. On the decision around the exact number, there will be some consultation with states and territories around numbers within jurisdictions. We are working through that at the moment.

Senator McLUCAS: The policy considerations are alignment with health and hospital networks and state government preferences. Are there any others?

Prof. Baggoley: There is certainly an alignment with local hospital networks where possible. In some areas, there may be clusters of those. But that is the key consideration in terms of numbers.

Senator McLUCAS: How many local hospital networks do we have at the moment?

Prof. Baggoley: I understand there are around about 170. But I will double-check that number for you during dinner.

Senator McLUCAS: The proposal is that we put a number of local hospital networks into one primary healthcare network.

Prof. Baggoley: That is correct. A number of local hospital networks would come together and would form the boundary for the primary health network.

Senator McLUCAS: What is the policy rationale for that?

Prof. Baggoley: Professor Horvath's report, as you have indicated, came up with a number of recommendations and a number of issues. One of the issues that he came up with was that he felt that the current size of Medicare Locals—there are 61 Medicare Locals—was not very efficient, in terms of the activities that they had to perform. He felt it would be more effective if you had a smaller number of larger primary health

organisations. He felt that that would give greater ability to talk to states and hospitals. He also felt that it would give greater ability to have the expertise that is needed to effectively run primary health networks in a smaller number.

Senator McLUCAS: From the department's perspective.

Prof. Baggoley: No, that was his perspective.

Senator McLUCAS: It would be more efficient from the department's perspective to manage a smaller number of Medicare Locals, however named—primary healthcare networks.

Prof. Baggoley: It would potentially be, but I do not think that was raised by Professor Horvath in his report.

Senator McLUCAS: I am just trying to find the efficiencies of dealing with less numbers.

Prof. Baggoley: As I said, there was a number of different things that he looked at. To give an example, one of them is that it is quite difficult to carry out some of the activities of Medicare Locals at the moment where you need specialist expertise around such things as population health planning—for example, epidemiologists. There are not enough epidemiologists around the country, health economists or population health planners to actually duplicate them 61 times. He felt it would be more effective to have a smaller number and you could concentrate that resource there. He also came into some areas around the effectiveness of those organisations in planning, linking with local hospitals, linking with clinicians and those kinds of areas as well.

Senator McLUCAS: The number that has been promulgated around the place is that there will be 24. Is that under consideration?

Prof. Baggoley: I understand that that is a number that has been raised. That is correct. But a final definitive decision has not been made.

Senator McLUCAS: What is the process to come to an answer about the number of primary healthcare networks that we will eventually have?

Mr Booth: It is the process that we are working through at the moment and we will be talking to states and territories in terms of how this would work and numbers to discuss—

Senator McLUCAS: When do you expect that you will get to the answer?

Mr Booth: Very quickly. We are moving through the policy process here as quickly as we can.

Senator McLUCAS: Let us go now to the funding that is provided to Medicare Locals. What funding will be provided to Medicare Locals from now until 1 July 2015?

Mr Booth: Medicare Locals will be funded to continue the activities that they currently carry out in terms of front-line services. Their contracts have been confirmed to be in existence until 30 June 2015, so those contracts will continue going for that period of time.

Senator McLUCAS: So no change at all?

Mr Booth: At the end of the financial year what happens is that Medicare Locals submit their annual plans. They also submit their health needs assessments and they put forward proposals within those plans. We are in the process of looking at those plans at the moment and giving them an indication of what we think the funding should be for the year ahead. We are in the midst of that at the moment.

Senator McLUCAS: What will happen to after-hours programs in this transition phase?

Mr Booth: The after-hours program that is run by Medicare Locals will continue for the next year. The after-hours funding, as you know, went into the Medicare Locals flexible fund to work to improve after hours access. That will continue for the next year.

Senator McLUCAS: What information has been provided to Medicare Locals about the process from now to 1 July next year?

Mr Booth: There have been a number of initiatives, including the putting up of frequently asked questions on the Department of Health website. There have also been frequently asked questions done for Medicare Locals on a specific website that they access. In addition there was fairly soon after the announcement of the budget a webinar held where representatives of the department spoke to I think around 95 staff from Medicare Locals, including the majority of chief executives, to talk through what was happening and what the process would be.

Senator McLUCAS: Is it proposed that the current focus of Medicare Locals will change as they move to primary healthcare networks?

Mr Booth: The key focus for Medicare Locals is to continue providing the front-line services and patient services that they provide and to make sure that the contracts that they have are met and that the deliverables that they have with the Department of Health are met.

Senator McLUCAS: And post 1 July 2015?

Mr Booth: Post 1 July 2015, Commonwealth funding for Medicare Locals will cease.

Senator McLUCAS: How many staff are you expecting will lose their positions following 1 July 2015?

Mr Booth: I cannot answer that. We will need to work through it over the next year but we would expect that where services are being delivered those services would continue to be delivered and staff would novate over to service providers.

Senator McLUCAS: You expect that will happen?

Mr Booth: Yes. But we cannot give an exact figure.

Senator McLUCAS: So all the current functions of a Medicare Local will move into the activities of the primary healthcare network?

Mr Booth: We will be developing policy over the next few months in terms of the activities of primary health networks and what they will concentrate on. Professor Horvath indicated that there would be the establishment of clinical councils and community committees to work with primary health networks, so we will be working through their functions, and he also indicated that the new primary health networks should not be service providers but purchasers of services. So, there will be some changes and we will be working through that over the next few months.

Senator McLUCAS: It sounds like this is a realignment and rebadging activity rather than a refocussing activity. If all the services that are currently being delivered are going to continue to be delivered, I am at a bit of a loss to know what is really changing.

Mr Booth: As I said, this is as a result of Professor Horvath's review. I think the key things are that there will be a smaller number of them, to provide administrative efficiencies and to reduce administrative costs. There will be greater savings because of the economies of scale that they will have. They will have greater GP and local clinical involvement with them through mandated clinical councils and clinical advisory committees. As I say, crucially, the primary health networks will not be providers of health services, but they will be purchasers of health services. So there are a number of very significant differences to the Medicare Locals as they exist at the moment.

Senator McLUCAS: If the primary healthcare network is no longer the deliverer of services, do we expect there will be job losses there?

Mr Booth: Medicare Locals are private organisations and there may be a number of different directions in which Medicare Locals choose to go next year. They may become service providers, but they would have to compete for that within the market. So, as I said before, we cannot really be definitive about that at this point.

Senator McLUCAS: Does the department have knowledge of how many staff the various 61 Medicare Locals employ?

Mr Booth: Directly employ? It is difficult to give an exact figure because different Medicare Locals have different models of working. Some of them directly employ; some subcontract and that kind of thing. So it is difficult to give an exact number to that question.

Senator McLUCAS: Is the department of the view that in every region in Australia there is the capability outside of the Medicare Local to deliver specific programs?

Mr Booth: That would be something for the primary health networks to investigate and is what Medicare Locals are looking at.

Senator McLUCAS: My understanding is that, in many cases, the Medicare Local has taken on the delivery of services because there has been an assessment made of the capacity in a region, particularly in rural and remote areas, to deliver particular programs. Therefore, they have undertaken that program work themselves.

Mr Booth: I should have made it clear as well that one of the areas within Professor Horvath's report was exactly as you have said: in areas of market failure, there may be a case for PHNs to actually provide the services, but that would be on a case-by-case basis. As you have said, that will be primarily in remote areas of the country. So they may do, but, as a general rule, they would not be providers of services.

Senator McLUCAS: Has any assessment been made of how many primary healthcare networks will be put in place by state at this point in time?

Mr Booth: Not specifically. As I said, we are working through that process at the moment.

Senator McLUCAS: If we have 24, you would expect that maybe in the state of Queensland you might have three or four. Is that reasonable to predict?

Mr Booth: It could well work out like that. As I say, we are just going through that process at the moment.

Senator McLUCAS: What consultation with the community will happen before those decisions are made?

Mr Booth: The primary consultation will be with states and territories. Certainly, for Professor Horvath when he did his report, there was a process there around consultation. He consulted with key bodies and key peak bodies. In addition, there was a submission process within that when he came up with that, so we would anticipate that there would not be another large consultation process here.

Senator McLUCAS: I will speak quite parochially now. If the far north Medicare Local gets subsumed into Townsville and Mackay, I dare say that constituents of mine might have a view on that. It is something that I expect the government would want to be aware of. If the three northern Medicare Locals get pushed into one, I dare say that the *Cairns Post* might have something to say, and so might the *Townsville Bulletin*. Whenever you tell us in Cairns that we are going to be run out of Townsville, we always have something to say. These are real things and there are real reasons why the very excellent work done by the Townsville-Mackay Medicare Local is very different from the Central and North West Queensland Medicare Local, which is, once again, very different from what the Medicare Local based in Cairns does, because the people it is serving are different. They have different health needs, and that is why Medicare Locals are different.

CHAIR: I think that guarantees the *Townsville Bulletin* and the *Cairns Post* will respond!

Senator McLUCAS: That is not what I am after. I am after a process of consultation so that the department is knowledgably making decisions about amalgamating some of these Medicare Locals, which may make them less responsive to local need. What will happen to the work that the Medicare Locals have done to date, particularly, Mr Booth, given your comment that these are private entities? Will they be required to provide to the new funded organisation their assessments of local health status, their burden of disease, their data collections? We do not want to waste all this work.

Mr Booth: To take the health needs assessments as an example, they are publicly available documents. As we work over the next year, we would expect a collaborative process, in terms of Medicare Locals and PHNs as they develop. But a lot of the information and a lot of the work that they have is in the public domain in terms of that health needs assessment work that they do.

Senator McLUCAS: Certainly there are final documents, but there is a lot of material that sits behind that. Will there be a requirement that those private entities have to hand over this information?

Mr Booth: We have not got into the policy work around that.

Senator McLUCAS: What funding is available currently to the Australian Medicare Local Alliance?

Mr Booth: That is a slightly difficult one to answer because the Australian Medicare Local Alliance gets funding from more than just the Commonwealth. It gets funding from a variety of different areas. I will take the exact amount the alliance gets from the department on multicentre because it does attract core funding but it also has had funding, historically, for a number of different programs from different areas within the department. In addition, it is a private organisation and we know that it gets funding from other sources.

Senator McLUCAS: If you could provide the Health money, and what are the costs that would be associated with the winding up of the AMLA?

Mr Booth: We are just working through that at the moment. We are working closely with the alliance in terms of determining what those costs will be.

Senator McLUCAS: Back to the transition from Medicare Locals to primary healthcare networks, the budget says that the cost of the transition will be met from within the existing resources. What bucket of money will that come from?

Mr Booth: That will come from the funding that is available at the moment for Medicare Locals. We are anticipating working with Medicare Locals to see what funding is available to enable us to do that. But basically we have got that envelope to work within and that is what we are looking at at the moment.

Senator McLUCAS: So the winding up will actually come out of their core funding?

Mr Booth: The winding up in terms of?

Senator McLUCAS: The transition from Medicare Locals to the primary healthcare networks?

Mr Booth: There will be an amount of funding that we are currently looking at in terms of things like carryovers and those kinds of areas. We will be looking at all available funding there and as I said working within that funding envelope to see what we have available to actually do the transition process.

Senator McLUCAS: Is there a potential that moneys that are currently allocated, or that Medicare Locals believe have been allocated, for direct delivery of services will be used in the transition process?

Mr Booth: Medicare Locals need to continue doing front-line services. As I say, we are currently looking at liabilities and what will happen to those liabilities over the next year. We are working to ensure that front-line services and services that are provided are not impacted by this at all. We will work on that to make sure that does not happen.

Senator McLUCAS: Where in the budget would you expect the cost of transition to come from?

Mr Booth: We would expect that to come from work that we are doing at the moment. As I say, we are currently looking at set annual plans that are ongoing. We are looking at things like carryovers from this year to next year and to seeing how much funding is available there. We are also looking at some of the activities that are carried out to see what funding is being put into them. As an example, the Medicare locals may have put funding aside for new capital projects which we would not expect to go ahead now. We are doing that process at the moment. It is quite a detailed piece of work, as you can imagine, but it is basically seeing what funding is available, how much is available for those front-line services and how much we can use for that transition process.

Senator McLUCAS: How will primary health organisation board members be appointed?

Mr Booth: Formal decisions have not been made yet.

Senator McLUCAS: What sort of entity can be eligible to apply to become a primary health organisation?

Mr Booth: The policy direction at the moment is that public and private organisations would be eligible to become primary health networks.

Senator McLUCAS: Anybody?

Mr Booth: Again, we are just working through the policy work at the moment to determine the tender documentation that will be needed to be provided later this year to give those kinds of details.

Senator McLUCAS: Has there been any analysis of the cost to state governments from the abolition of the Medicare Locals?

Mr Booth: Not specifically by the department.

Senator McLUCAS: Have you done any work on what areas will be cost shifted to state governments through the abolition of the Medicare Locals?

Mr Booth: As I said before, we would expect that all services that Medicare Locals are providing to clients will continue. We would anticipate that those services continue.

Senator McLUCAS: Minister, given the conversation we have just had with Mr Booth for some time, how do we defend Mr Abbott's promise that we are not shutting any Medicare Locals given they are all going?

Senator Nash: We were very clear during the election that there would be a review into Medicare Locals as part of the budget process. There has now been the announcement that we will be implementing all of those recommendations.

Senator McLUCAS: But he said in the third leaders debate in August of last year these words:

We are not shutting any Medicare locals.

The truth is they are all going. All 61 of them will go at the end of next financial year.

Senator Nash: All I can do is reiterate that in the budget we indicated that the recommendations from the review would be implemented.

Senator McLUCAS: So he told a fib?

Senator Nash: I can just reiterate that as we said in the budget all of those recommendations would be implemented.

Senator McLUCAS: I think he told a fib. Can I go to one particular Medicare Local, which is the Lower Murray Medicare Local, which I understand works across the state boundary of New South Wales and Victoria. That will not fit with a local hospital network of course. Has there been consideration of the continuation of their boundary to accommodate the special needs of those cross-boundary issues on the Murray River?

Mr Booth: Not at the moment, no.

Senator McLUCAS: Nothing at all?

Mr Booth: We have not done specific work around that particular Medicare Local's area.

Senator McLUCAS: You are aware of a letter from Dr Booth, the chairperson of the Lower Murray Medicare Local?

Mr Booth: Which letter was this?

Senator McLUCAS: I was provided with a copy. I dare say he wrote to everyone—probably to your minister, as well.

Mr Booth: Probably. I have not got specific details on that, I am afraid.

Senator DI NATALE: Will a new peak body be established to effectively represent the primary health networks in the same way as the Australian Medicare Local Alliance?

Mr Booth: There will not be Commonwealth funding for a new peak body.

Senator DI NATALE: Is the management of each of these Medicare Locals out to tender?

Mr Booth: For the new organisation?

Senator DI NATALE: Yes—for the primary health networks.

Mr Booth: For the primary health networks, the intention is that there will be a tender process done towards the end of the year.

Senator DI NATALE: Can I ask about a specific tender? Medibank Private Health Solutions has expressed interest—and in fact I understand are engaged—in putting together a tender for the new primary health networks. Are you aware of that?

Mr Booth: There has been no tender documentation produced.

Senator DI NATALE: My understanding is that they are currently working on that and that that is their intention—to submit a tender. I am interested in how you would deal with a tender from Medibank Private Health Solutions given that the government is a major shareholder in Medibank Private. Would that not represent a major conflict of interest if they were to submit a tender?

Mr Booth: I think what we will be doing between now and when the tender comes up is policy work around probity issues—conflicts of interest and how we deal with those kinds of issues. We have not done that yet.

Senator DI NATALE: If Medibank Private were to put in a tender, how would you deal with that conflict?

Mr Booth: I cannot answer that at the moment. We are not at that stage yet.

Senator DI NATALE: But you agree that, given that the government is a major shareholder, it would represent a serious conflict of interest?

Mr Booth: As I said, I really would not like to comment on that position yet. We are not at the tender process. We have not got that far down the track.

Senator DI NATALE: Professor Halton, if Medibank Private are submitting a tender for a primary healthcare network, given that the government is a majority shareholder, how do you intend to deal with that conflict? I understand that is exactly what they intend to do.

Prof. Halton: To be honest with you, it is too early to tell. They do tender for work at the moment, government work. They own a business that does large government tenders. They have not been ruled out of those processes. But, in this particular process, we have not got to that point of decision making yet.

Senator DI NATALE: Do you have a process? Would you envisage having to develop a process to deal with the conflict of interest?

Prof. Halton: Whenever we go to market for anything, we have to have absolutely rigorous approaches to probity. We have probity advisers and all the rest of it. I can assure you that that will happen in this case as well.

Senator DI NATALE: The concern would be that, given that Medibank Private is ready for sale, or will be sold shortly, this would give them a competitive advantage and affect their share price—if they are engaged in the primary healthcare space in a way that none of their other competitors would be.

Prof. Halton: If they are eligible. I think everyone understands the need for competitive neutrality. As I said, we have not got yet to the stage in the process where these details have been worked through, but we are very conscious of issues around competitive neutrality.

Senator McLUCAS: The two programs I am interested in are the Partners in Recovery program and Access to Allied Psychological Services. Can you give us an understanding, Mr Booth, of what you expect will happen in the transition period—given that Medicare Locals are the fund holders for ATAPS funding and many Medicare Locals deliver Partners in Recovery?

Mr Booth: I have a couple of general comments. For mental health programs generally, there is a process being undertaken at the moment, as you know, by the Mental Health Commission. They are reviewing all mental health programs currently being provided. So, for mental health programs in general, funding has been approved for the next financial year, for the next 12 months. For example, ATAPS funding continues with Medicare Locals for the next 12 months. Anything after that will be in the light of recommendations from the Mental Health Commission's review. That is really the story across mental health programs generally.

Senator McLUCAS: So you will wait until the commission brings down its report at the end of the year before undertaking any planning for transition?

Mr Booth: We will need to look at that. But, as I said, in general for all mental health programs there is continuity for 12 months. And yes, we wait for the results of the Mental Health Commission's review of mental health programs.

Senator McLUCAS: So, you are doing no preparations for transition for those two programs [inaudible] largely by Medicare Locals?

Mr Booth: For the ATAPS program we are ensuring that funding is going to Medicare Locals so that the program is delivered for the next 12 months. We will then do policy work when the Mental Health Commission produces its report, and we will do that at the time.

Senator McLUCAS: How will the change of geographical boundaries that is envisaged impact particularly the Partners in Recovery programs, which are very much based on Medicare Local boundaries? Will there be a re-tendering of those PIR programs?

Mr Booth: We will need to look at those details when we actually get nearer to the time and when the boundaries are determined and we get more into the tender process. So really I cannot say at the moment exactly what will happen, because we do not know the numbers of those boundaries exactly. But we will need to work through that.

Senator McLUCAS: And do you expect that the Partners in Recovery Program will be re-tendered as a result of the transition?

Mr Booth: As I said, I cannot answer that at the moment. We are waiting for the results of the commission's review.

Senator McLUCAS: My recollection of the way PIR was tendered is that is was a very collaborative tender, if you know what I mean. My assessment is that it has been highly successful. How long were those original contracts for Partners in Recovery for?

Mr Booth: For Medicare Locals in general the contracts were for three years, through to the end of not next financial year but the financial year afterwards.

Senator McLUCAS: Surely there could not be a break in that contract?

Mr Booth: As I said, we would expect for services that are being provided and front-line services to have continuity of service delivery, and one of the key things we are working to ensure is continuity of service delivery. And that is what we will do with the ATAPS program as well if that is the way the policy develops next year after the Mental Health Commission has done its review.

Senator McLUCAS: The deferral of the rollout of the 13 Partners in Recovery organisations or services was delayed for two years in the budget. What is the policy rationale for taking that $53.8 million that was earmarked for direct service delivery to people experiencing mental illness to the medical research future fund?

Mr Booth: As you said, there are currently 48 Partners in Recovery initiatives going on around the country. The government made the decision that as the Mental Health Commission was doing its review it would be inappropriate to do the final 13, so there has been a deferral, as you said, for this financial year and the following financial year.

Senator McLUCAS: Minister, maybe you can answer this question. We still have 13 Partners in Recovery programs to be rolled out. This budget takes $53.8 million from allocated funds for those direct services to people experiencing mental illness. But that money has just been scooped up and given to the medical research future fund. That is a completely different use of $53 million. What is the rationale for taking it out of direct services to people with mental illness for the never-never medical research?

Senator Nash: You would know that that funding was provisionally allocated. The government thinks it is appropriate, as Mr Booth has indicated, that we wait until we get the report from the commission's review before we move to looking to implement that. And I think that is a very sensible and prudent thing to do, so we can determine exactly the nature of the efficacy and efficiency of the current services. But I think it is very useful to note those 48 existing Partners in Recovery programs. I think it is $430 million over 2012-13 to 2015-16 that is still being expended. So it is very much a decision that was taken in a very prudent manner to ensure that the service delivery is being done appropriately before there is any further expenditure of funds.

Senator McLUCAS: But why wasn't it parked somewhere? I do not agree with the fact that it has been deferred, but it has. But instead of giving it over to the research fund, why wasn't it simply parked in the budget somewhere?

Senator Nash: That was a budget decision.

Senator McLUCAS: Is there any chance to get that $53 million back out of the medical research fund?

Senator Nash: Well, that was the decision of the government to do that. I think it is appropriate that we do review the current arrangements to ensure that going forward they are being efficacious in terms of the delivery, and I think it is a decision of government that stands.

Senator McLUCAS: So, no commitment to continuing in 13 geographically discrete areas, and give the money away to a different application of those funds totally?

Senator Nash: As I have indicated, it was a budget decision. This is a government that is very focused on ensuring that we have efficient and targeted use of taxpayers' dollars. We will continue to do that. This was a decision taken in that content and was a decision of the budget arrangements.

Senator McLUCAS: Do you understand the anger in the mental health community that scarce funds that we get allocated into this part of the portfolio have just been scooped up and given away to health research and with no undertaking or commitment from the government that those 13 discrete regions will end up with some sort of direct service to people living with mental illness?

Senator Nash: I have indicated that the government is very focused on ensuring that we make responsible, informed decisions on the efficacy of programs. We have done that in relation to that. At the same time, though, you would be well aware that there is investment in the area of mental health—the national Centre for Excellence in Youth Mental Health, $18 million over four years, and the extra Headspace sites, as you would note. I would not like—

Senator McLUCAS: That is not the purpose of Partners in Recovery.

Senator Nash: I know, but I would not like the committee to be under any kind of misconception that the government is not committed to ensuring that we invest in mental health.

Senator MOORE: Minister, in terms of the areas where Partners in Recovery is not going to be rolled out, and with as much research program—people in the community were looking at it very carefully—is there a strategy by the government to actually talk with the communities where their programs are not going to be rolled out?

Senator Nash: In terms of the specific detail I would have to take that on notice.

Senator MOORE: Specifically around PIR. It is just, as Senator McLucas was saying, PIR was kind of the showcase of that whole program over a period of time, and it was being rolled out sequentially, as we know with most programs. And there were 13 that had yet to be funded, but there was an understanding that because it had started it would continue. It is quite clear that the government made the decision, and that is what governments do; I know that. But, given that, I am just really keen that those communities that were expecting it actually have some commentary about what is going to be available for them and the process you have explained. So, can we find out whether something is going to happen?—not generally, but for those 13 communities.

Senator Nash: I can certainly take that on notice for you.

Senator McLUCAS: Mr Booth, can I have a list of those 13? I can work it out by exception, but I am sure you have a list of the 13.

Mr Booth: Yes, we can provide you with a list, certainly.

Senator WRIGHT: I am interested, similarly, in the decision to take the funding from Partners in Recovery for these 13 and put it elsewhere—$53.8 million. And I am interested in the commentary by the Public Health Association of Australia asserting that this will 'increase the burden on families, communities and the acute health care sector'. I have heard over and over again throughout these estimates hearings that 'this is a budget decision'

and 'we chose to not fund this program'. But there are a million budget decisions that could be made and only some that are made, and I am always interested in understanding what predictions or what modelling or what assessment evaluation there is that underlies the decision, because every decision has consequences. It sort of follows up, I think, from what my colleagues were saying: what review or analysis occurred to inform the decision to cut this program's funding? Was there any consultation with anyone in the mental health sector before the decision was made? Or was it purely a choice of these dollars as opposed to other dollars?

Senator Nash: I do not know whether you were in the room. Mr Booth made some comments earlier, as have I.

Senator WRIGHT: I probably was not; I beg your pardon.

Senator Nash: That is absolutely fine. We are waiting until the final report from the Mental Health Commission review to actually inform the appropriateness of that program, and obviously right across the board of the mental health sector, before there is any more expenditure of funds in that particular area.

Senator WRIGHT: I have heard that about many programs. The trouble is that in the meantime the people who were going to be receiving services from that program are not receiving those services. So, you would understand that there are consequences of making that decision or that deferral, and I am interested in what evaluation, what predictions, what consequences were considered before that decision was made.

Senator Nash: In terms of the decision in the budget context, I cannot really comment. But I am happy to take it on notice insofar as I can get an answer to that question for you, not being privy to it.

Senator WRIGHT: So you do not know whether there was any consultation with the mental health sector about the consequences of deferring that funding pending the outcome of the review of the National Mental Health Commission? Is that what you are saying—you do not know?

Senator Nash: I would not like to make an assumption, so I will take that on notice.

Senator WRIGHT: Also—because I presume you would not know this either—perhaps you could take on notice what programs will fill the gaps that the cuts leave in the meantime until there is some subsequent decision to either roll those out and fund the program further or not.

Senator Nash: Certainly.

Senator WRIGHT: Thank you. Also—and, again, this may have already been asked, and it has been generally asked—how will mental health concerns and community based organisations be represented in primary health organisations? And, specifically, will they be eligible to join PHO clinical councils and PHO community advisory councils?

Mr Booth: In terms of the clinical aspects, as I described earlier, there are going to be clinical councils established. These clinical councils will be GP led, and they will have the purpose of working through care pathways to ensure that the primary care sector and the secondary care sector are effectively linked up and for particular issues such as mental health there are effective care pathways put in place for clients to actually work through the system. So we would expect, as I said, that those will be GP led and they will have a variety of clinicians on them. I cannot go into a great deal of specifics at the moment. We are still working through the policy around that. And in terms of your question around membership we are still working through the policy and the development around that.

Senator WRIGHT: In terms of that policy development, what consultation is there then with the mental health sector generally? Obviously clinicians are important but community based organisations are absolutely crucial in this area as well.

Mr Booth: That is correct. As I said previously, Professor Horvath did a significant amount of work in terms of talking to a range of different organisations, and he also did a submission process whereby people provided submissions to him, and I know mental health issues were raised within that. We are still working through consultation and work that we are doing at the moment. We are still in the midst of doing that.

Senator PERIS: With regard to the GP superclinic that was proposed for Darwin, can you give me an update on the process of what took place in the cancelling that GP superclinic?

Mr Booth: There was a decision of government made to cease Commonwealth funding for three funding recipients for three GP super clinics. It was a decision of government.

Senator PERIS: Did the department provide advice to the ministers to support these cancellations?

Prof. Halton: We do not ever talk about the nature of any advice we provide. Certainly the government was in receipt of advice about the GP Super Clinic program.

Senator PERIS: Why were these three proposed out of others? Can you answer that?

Mr Booth: Again, it was a decision of government.

Senator PERIS: Were the funding recipients consulted on this decision?

Mr Booth: They were not consulted before the decision.

Prof. Halton: I might make one point about the three projects. They had all been afoot for a very long time and had not actually progressed, turned a sod or made any progress of substance over a long period.

Senator PERIS: I know there was talk that $5 million was set aside for the proposed one in Darwin. Will the money that was set aside for that be reallocated to another jurisdiction, or will that funding be kept in the Territory for something specific to Northern Territory health?

Mr Booth: In terms of funding, it would come back to Health. It would not go to the NT government.

Senator PERIS: So there is no discussion or anything taking place for that $5 million to be kept for another program in the Northern Territory?

Prof. Halton: No.

Senator McLUCAS: To follow Senator Peris, Ms Halton, could you describe to the committee the obstacles that you indicated had provided difficulties for the establishment of the Darwin clinic.

Prof. Halton: Mr Booth can go through them chapter and verse. But to my certain knowledge it has had a very chequered history.

Senator McLUCAS: My understanding was that there were changing views from the NT government about the location and activity. Mr Booth, you are nodding—why don't you respond.

Mr Booth: That is correct. As the secretary has indicated, this particular GP super clinic had a particularly chequered history. There was an agreement with the NT government that land would be found for the GP super clinic. From memory, the initial piece of land that was found was changed. So we had a first piece of land, then it was moved to a second piece of land. There were issues around infrastructure and linkage to main services for that particular one. Then, at the end, it was finally moved to a third site, and that was where the latest work had been done.

Senator PERIS: In what years did those discussions take place?

Mr Booth: Darwin was one of the early ones—our second round. The announcement was in 2010-11.

Senator McLUCAS: Did any of those three super clinics that are being terminated—Rockingham, Darwin and Wynnum—have co-investments as part of the final plan?

Mr Booth: There was no formal co-investment in terms of co-investment with state governments—if that is the kind of thing you mean—as we have had with others. There was solely Commonwealth funding going into them. Having said that, as you will be aware, some GP super clinics have put their own funding in or brought loans in and that kind of thing. I am not aware of the details around those. But, in terms of the majority, funding came from the Commonwealth.

Senator McLUCAS: Given where we finally landed—or did not land, frankly—with Darwin, was the Territory government still going to allocate land for the establishment, once it bounced around its location three times?

Mr Booth: I do not know what the NT government is intending to do.

Senator McLUCAS: What will happen for after-hours services in particular and for the GP services more broadly in those areas now?

Mr Booth: Those services will continue. The clinics had not been built, so there were no services.

Senator McLUCAS: So the undersupply of services in those areas will remain.

For the three different clinics, what other services were those clinics proposing to provide?

Mr Booth: With those services, as with most GP Superclinics, there was an indication that they would have to provide GP services as well as a range of allied health services with the aim of meeting multidisciplinary team based primary healthcare.

Senator McLUCAS: Maybe Mr Booth if you could provide on notice the list of allied health services that each proponent was hoping to delivery.

Mr Booth: For each of those three?

Senator McLUCAS: Thank you. When was the Rockingham clinic approved?

Mr Booth: That was the 2010-11 commitment as well.

Senator McLUCAS: For the record, what were the obstacles in achieving agreement around Rockingham?

Mr Booth: It was, as I said before, a decision of government, but these were clinics that had not progressed particularly far. With Rockingham, in particular, I think there were land issues. Rockingham had a lease just done, but I would need to take on notice any specifics around the building or the planned building.

Senator McLUCAS: I understand the identified need in that area was particularly around youth mental health services through headspace and that service was going to be co-located within the superclinic. Is that correct?

Mr Booth: For which superclinic, Senator?

Senator McLUCAS: Rockingham.

Mr Booth: I know in terms of headspace they are currently going through the new headspace sites at the moment and it will be a matter for headspace to determine where they need to put that service.

CHAIR: When was it proposed that the Rockingham Medicare Local would be operational?

Senator McLUCAS: Superclinic.

CHAIR: I am sorry, Superclinic. On the current timetable that you have.

Mr Booth: I would need to take specific dates on notice—when it was intended to be built, operational and fully going.

CHAIR: So it had been, what, just on three years or more?

Mr Booth: That is the process to date.

CHAIR: A figment of someone's hopes and dreams.

Senator McLUCAS: Had contracts already been signed for the three sites?

Mr Booth: Contracts in terms of?

Senator McLUCAS: Contracts with the proponent.

Mr Booth: Contracts had been signed—yes, that is correct.

Senator McLUCAS: So what is the process that the department has to follow now with respect to contract cancellation?

Mr Booth: The contracts with those three GP superclinics, as with many Commonwealth contracts, have a clauses in them that allows the contract to cease the funding. We are currently working with those funding recipients at the moment to see if there are any liabilities and there are discussions ongoing with the recipients.

Senator McLUCAS: And did the department require legal advice in relation to the contract terminations?

Mr Booth: Providing advice?

Senator McLUCAS: Did the department need to go and receive some legal advice about those contract terminations?

Mr Booth: Yes. We have legal advisors for the GP superclinic program and we needed to contact the funding recipients with formal legal advice to indicate what would happen and the way forward.

Senator McLUCAS: Do you expect any legal action to occur as a result of the termination of these contracts?

Mr Booth: No, Senator.

Senator McLUCAS: And on notice, can you provide how many MBS services have been provided by each of the GP superclinics, how many after-hours services are being provided by each GP superclinic, and—

CHAIR: Is that for all of them or just the operational ones?

Mr Booth: We are not able to provide specific information for each GP superclinic. We tend not to give it at an individual level, because that is commercial information. We keep information at a very high level across the whole program and we can certainly give you that information but not for each one.

Senator McLUCAS: Of course, that was stupid question; I am sorry about that. A lot of the clinics had a requirement that they would bulk-bill.

Mr Booth: A lot of the clinics were strongly encouraged to bulk-bill as part of the program

Senator McLUCAS: I think in the first iteration it was a contractual requirement.

Mr Booth: I thought it was strongly encouraged but I can certainly check.

Prof. Halton: We can check that, Senator. My memory is that in a number of instances they indicated who they might bulk-bill and gave us some expectations about what proportion of the people that they saw could expect that kind of billing arrangement.

Senator McLUCAS: And do you have, Mr Booth, across the whole program the level of bulk-billing that is occurring through GP superclinics?

Mr Booth: We could have a look.

Senator McLUCAS: Then we could make a judgement about what might happen when the GP supertax comes in. Thank you.

Senator MOORE: In the reporting requirements of the GP superclinics, I thought one of those was what they were doing around bulk billing.

Mr Booth: There are a variety of reports on requirements, yes, and that is one of them.

Senator MOORE: So in terms of gathering the information, at least it should be there.

Mr Booth: That is correct. There is a requirement to report to the department on a variety of measures.

Senator PERIS: Just to clarify, that $5 million that was set aside for the superclinic is not going back into any other health programs.

Mr Booth: I would need to take that on notice. That is my understanding.

[18:01]

CHAIR: As there are no other questions around superclinics, we will move to Primary Care Practice Incentives, program 5.2.

Senator McLUCAS: The budget measure for Practice Incentives Program Teaching Payment, could you explain the rationale for that budget measure?

Mr Booth: The budget measure was an election commitment to double the payment, with the intent of increasing the amount of teaching that is taking place within GP practices.

Senator McLUCAS: What is the underlying principle for that? Practice teaching is great, but what is the figure $10 to $200?

Prof. Halton: It was an election promise, commitment.

Senator McLUCAS: What was the rationale behind increasing the Practice Incentives payment?

Senator Nash: It is very straightforward. We know there is an enormous burden that sits on our GPs in terms of the training they do. Particularly in rural and regional areas, we need to ensure that we have those opportunities for training and, commensurately with the works that GPs doing that training, the government recognised there was a need to increase that payment. From memory, it is a three-hour period. It was very much recognised that the GPs need to be recognised for the training they do.

Mr Booth: It is a three-hour period, yes.

Senator McLUCAS: How are we rolling that out?

Mr Booth: That will roll out from 1 January 2015 onwards. Essentially, the process will be exactly the same as the current process for the teaching incentive. Practices will claim it through the usual routes, and the payment will be double what they are receiving at the moment.

Senator McLUCAS: It is just a doubling of the payment to that GP practice.

Mr Booth: Everything remains the same. It increases from 100 to 200.

Senator McLUCAS: It is the intention that we increase the number of events of training that happening at various GP practices around the country.

Senator Nash: That is exactly right. And recognising as well that we have just increased the GP training places by 300, this marries in with that decision as well. It is really important that we provide as much opportunity, as you are very well aware, Senator McLucas, along the pipeline to ensure that we have those opportunities for training in GP practices. It is getting better. Obviously, historically, there was not the required amount of intent from young medical students to head towards a career in GP. As you would be aware, that has now improved greatly, but it is still important that we provide those opportunities through that training pathway.

Senator MOORE: That was my question, in terms of how the amount of $238 million was determined. It is $238.4 million over the next five years. Is that linked to the number of students, is it linked to the number of practices that are currently doing it? Where does that amount come from?

Senator Nash: I will get Mr Booth to answer but my answer is that it is a straight doubling of the actual payments.

Senator MOORE: We have asked questions about this payment before, even at the $100, in terms of how do you establish the need, the work with the individual universities as to how they actually get the young people out there—where does the number come from?

Mr Booth: There was some modelling done in terms of the doubling of the payment and some assumptions made around the impact on demand of doing that.

Senator MOORE: Who did that modelling?

Mr Booth: The department did some of that modelling.

Senator MOORE: So it is internal modelling. And what were the parameters that you worked on?

Mr Booth: The doubling and the experience with the PIP program in terms of uptake when parameters change.

Senator MOORE: Was the increased number of students fed in as well?

Mr Booth: That is correct.

Senator MOORE: When is it reviewed?

Mr Booth: The PIP program is an ongoing process, as you know. There is not a formal review point. The government is at liberty at any time to look at the particular incentives and the levels of incentives and make changes to those.

Senator MOORE: Was there any internal review before the doubling?

Mr Booth: It was a government commitment so we did not—

Senator MOORE: I understand the theory of doubling, on the basis to repay the medical practices—we have had evidence from people at some of our inquiries about the extra effort it takes for a practice to provide this service and they talk about the incentives to do that, so I do understand that—but it was just to double it. It seems a significant increase and I want to know what the background is. The modelling was done internally and, as it goes along, you will get feedback and there will be reviews of how is it is going?

Mr Booth: That is right. As you know, payments for PIP are made quarterly and we monitor payments for all 10 PIP programs.

Senator MOORE: Has there been any misuse of the funding?

Mr Booth: Misuse of the funding?

Senator MOORE: Yes, when you are looking at when you pay quarterly and this amount of money goes out to GP places, have you found any misuse?

Mr Booth: That is probably a question for DSS as they actually run the program. There is an audit process put in around the PIP programs in terms of those double checks to make sure that practices are doing exactly what is said.

Senator MOORE: They have not told you of any?

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

Senator MOORE: Take it on notice, and I will also ask DSS.

Mr Booth: That is what they do, but as part of their—

Senator MOORE: It is just the scrutiny of that degree of expenditure.

Mr Booth: Sure.

Senator McLUCAS: What was the assumption in the figures for $238 million? How much was allocated to growth in the number of practices that will provide training?

Mr Booth: I do not have the details of that—I would need to take that on notice.

Senator McLUCAS: It is not just a straight doubling though—if it were, we would have no new services.

Mr Booth: There are various assumptions built into that modelling, as we have said, around the impact of doubling and what that does to demand—more GPs may take it up; that kind of thing. That was worked through but I do not have the details around that with me.

Senator McLUCAS: Could you provide that to us on notice?

Mr Booth: We will see what we can provide on notice.

Senator McLUCAS: In terms of the numbers of medical students undertaking training in general practice, how do you collect that data? Is it on a quarterly basis?

Mr Booth: I am afraid that is a Health Workforce Division question and I think they are on tomorrow morning. Numbers of GPs and training places and those kind of things do not really come into the PIP ambit.

Senator McLUCAS: So you essentially locate the money and then Health Workforce Division does the counting of actual numbers—

Mr Booth: The actual take-up of the PIP program we would do and we would monitor training processes and how that is done. We would monitor all of that. In terms of GP training in a wider sense, it would be Health Workforce Division who would do that work.

Senator McLUCAS: No, what I am after is the data. How many people are doing training currently under the current program? And we might monitor that over time.

Mr Booth: What we can say is the number of practices that claim the PIP payment. We know that, in the February 2014 quarter, 1,245 practices claimed a PIP payment.

Senator McLUCAS: Are these quarterly figures?

Mr Booth: That is a quarterly figure. It is done on a quarterly basis.

Senator McLUCAS: Can you give me a couple of years back from that? Do you have that with you?

Mr Booth: I have quarters but I do not have information going back. In February 2013, for example, which is the previous year, there were 1,177 payments.

Senator McLUCAS: I do not know if we can take that much further until we see the impact of this measure. Is there a cap on the number of general practices that can access the PIP payment—the teaching program PIP payment?

Mr Booth: For the PIP program generally, no, there is not. It is a demand driven program, a capped demand driven program. We manage within the allocation.

Senator McLUCAS: The payment is made to the practice—that does not necessarily indicate the number of students that have been trained in that practice. Am I right in saying that?

Mr Booth: Yes, it relates to the practice and the number of sessions that they have been doing.

Senator McLUCAS: Can you then extrapolate the number of students from that?

Mr Booth: We would get from that the number of teaching sessions done. It is possible that, in those teaching sessions, more than one student is being taught. So it does not necessarily correlate one to one. We would need to look at that.

Senator McLUCAS: The practice does not report on the number of students they have had for a particular session?

Mr Booth: As far as I know, the payments that are put in are based on teaching sessions.

Senator McLUCAS: So we will not be able to ascertain the growth in the number of students who have had training sessions at general practice?

Mr Booth: That is the information we get from the PIP program. I would need to take on notice whether we get any other information about training.

Senator McLUCAS: I would just like to see whether there is growth. There is increasing investment, but we need to track whether there has been growth. I have one follow-up question from Friday's session on Indigenous health for Ms McDonald. You can say, 'I have taken it on notice,' if you want to. At the end of our session, I asked you to provide us with a table that shows the 2013-14 budget and the figures for the out years that were indicated in it, and the 2014-15 budget with the figures for those out years indicated as well. This goes to the conjecture and questioning around what, in fact, is the total cut to health. Some of those cuts are in PM&C and some of those cuts are in the Department of Health. You took that on notice from me—thank you. Can you assist the committee by providing information about what is really being cut from Indigenous health?

Ms McDonald: The question that you asked relates to the Indigenous health program funding between what is shown in the budget papers between the two budgets. Certainly in terms of the health side we will work through those tables that are in the various budget papers and give you a reconciliation to show what the differences are. Essentially, there is—as you are aware—one measure, which is the consolidation of the various programs shown in the PM&C outcome, which has the $121 million net funding reduction. In addition to that, the other major component that affects the health figures is the move of some of the programs that were formerly in the

Aboriginal and Torres Strait Islander Health Program to PM&C. Those programs are the Indigenous substance misuse programs, and from memory they were of the order of about $60 million. The pattern that you are seeing is essentially made up of those two components.

There are a few other measures that affect the Indigenous health budget which are additions to funding which are shown in the health portfolio's budget document as well, but we are working with PM&C to do a reconciliation. Certainly, we can get you the reconciliation of the health side, and PM&C would then need to show you, once things had gone to them, anything that had happened to that because we do not have that information.

Senator Nash: Senator, as you were not at the hearing on Friday, if it assists, there is $3.1 billion being invested from 2014-15 to 2017-18, which is an increase of more than $500 million compared to 2009-10 to 2012-13

Senator McLUCAS: Minister, there is a cut of half a billion dollars in the forward estimates for Indigenous programs. It is indefensible. It cannot be defended. You can talk about the quantum of money that is allocated, but the reality is that there is a cut of more than half a billion dollars in Indigenous programs from the Prime Minister who said he wants to be the Prime Minister for Indigenous Australia. It is indefensible.

Senator SMITH: To be fair, the budget measure does talk about waste and duplication in Indigenous funding, to be completely accurate about it.

Senator McLUCAS: And where is the waste and duplication? Let us identify it.

Senator SMITH: I asked those questions of Senator Scullion. He was able to demonstrate the point well.

Senator McLUCAS: I do not think so.

Senator MOORE: Can I ask some questions on the interaction between the Indigenous health program and the health program. I asked Senator Scullion this the other day in terms of the ministerial relationship. Always, I think the responsibility for health goes with the health ministries and where it crosses over with Senator Scullion's responsibilities and then the Prime Minister's responsibilities through Prime Minister and Cabinet. The Indigenous substance issue that I have worked with mostly is petrol sniffing, and we have done so much work in that area. Who is the responsible minister for issues around petrol sniffing and the huge health impact that goes with that?

Prof. Halton: PM&C have the lead on substance abuse which includes petrol sniffing. You know that I have personally taken a great interest in this over many, many, many years.

Senator MOORE: Yes, we have had many discussions on it.

Prof. Halton: Yes. They have primary line of responsibility, but I can assure you that there is a lock-step, cheek-by-jowl—every other image you want—relationship between the people in PM&C who are working on this and my people. Exactly as you say, there is an incredibly close relationship between the health consequences of something like petrol sniffing and the work on substance abuse.

Senator MOORE: And the whole social determinants of health process which you work on.

Prof. Halton: Indeed, but I think we do have to remind ourselves that it is a bit like that conversation we were having earlier today about where you draw the line in grey here, black here or white here. That is a bad image, but you understand my point. We have kept all of the primarily health focused activity. We have retained responsibility for primary health care; the minister is responsible. But, when we got into substance abuse, which, of course, as you know, has relationships with those broader areas, that is where the line was drawn, but we are keeping in extraordinarily close contact.

Senator MOORE: I asked many questions of Ms McDonald and she answered, and she was saying she will give some more information about the pressure point as to where an issue crosses between the two groups and also the communication network between those areas. I am looking forward to that, Ms McDonald.

Prof. Halton: The other thing to remember is that the people who went are our former officers, so they have all those contacts with us.

Senator MOORE: Thank you.

CHAIR: Senator McLucas has whistled up some new questions on the after-hours clinics—is that right?

Senator McLUCAS: The review of after-hours services and support—I am sorry, I flipped over this inappropriately. The health budget statements outline that a review is going to occur in relation to after-hours services and supports. Can you provide us with some information on that?

Mr Booth: Yes. It was one of the recommendations within Professor Horvath's report that the after-hours program that was being run through Medicare Locals be reviewed. As we said before, the recommendations have

been accepted by government. We do not have details as yet as to the form of that review, but the intent is that the review will run alongside the establishment of PHNs, so over the next year we would expect to be doing that review.

Senator McLUCAS: What were the elements that Professor Horvath identified that motivated a review to be undertaken?

Mr Booth: Professor Horvath, in general, identified that, whilst some Medicare Locals were very good in the area of after-hours, there was considerable variability across the country. He also identified that they had not necessarily been very good at contacts with general practice and that a lot of general practitioners and practices felt alienated or outside of the process. He felt that, with the variability across the country, that was something he felt needed to be looked at. You will also be aware that one of the terms of reference that Professor Horvath had in doing that was to look at programs carried out by Medicare Locals, including after-hours, so he specifically looked at that and provided advice on that.

Senator McLUCAS: Do we have any trends in levels of access to after-hours services that have followed the implementation of the program to task Medicare Locals with providing after-hours services?

Mr Booth: There will be certain figures available. There are a number of areas in after-hours. Obviously, there are MBS after-hours items. I do not have the details of specific MBS items, but there are specific ones there. Medicare Locals put in place contracts with general practices to provide different services, but those were contracts and, again, will not necessarily give a trend around those things. The final area is the GP after-hours helpline. But, in terms of activity, I do not have anything specific as to what has happened linked in with that at the moment. We would need to take that on notice.

Senator McLUCAS: When did we start that program?

Mr Booth: The after-hours?

Senator McLUCAS: Yes. It started when we began Medicare Locals.

Mr Booth: Medicare Locals started in 2011, but they were introduced in three tranches. Some started in July 2011 and the final ones came on board a year later. The after-hours program then rolled in after that and was put into the Medicare locals flexible fund.

Senator McLUCAS: When was that?

Mr Booth: That would have been last year, in 2013.

Senator McLUCAS: So we really do not have any good data to make judgements.

Mr Booth: I will double-check that date for you over the dinner break and confirm that.

Senator McLUCAS: We really would not have much data to make any judgement about trends in access to after-hours services yet, would we?

Mr Booth: They have been doing it for a year. That would be the data that would be available.

Senator McLUCAS: Okay. Can I ask that of the medical services division?

Mr Booth: I think we will take it on notice and see what information we can gather from that.

Senator McLUCAS: Thank you. I dare say it is early days, but has any work been done on the terms of reference?

Mr Booth: There is some initial work being done and we are developing that at the moment.

Senator McLUCAS: Who will conduct the review?

Mr Booth: That is a decision of government. That has not yet been made.

Senator McLUCAS: Is there a view from the minister about who should conduct this review?

Senator Nash: I am not aware.

Senator McLUCAS: Could you provide an answer to that?

Senator Nash: I will take it on notice, certainly.

Senator McLUCAS: Thank you. Is it intended that the terms of reference be made public?

Mr Booth: That would be a decision of government again.

Senator McLUCAS: Minister?

Senator Nash: Again, I will take it on notice.

Senator McLUCAS: How much funding has been allocated to conduct the review?

Mr Booth: That has not been finalised yet. As I said, we are in pretty early days around this and still working on it.

Senator McLUCAS: Where would that money come from, normal processes notwithstanding?

Mr Booth: Again, I would need to double-check.

Senator McLUCAS: How many calls has the GP helpline had since its commencement in 2011?

CHAIR: What year?

Senator McLUCAS: 2011.

Mr Booth: The GP after-hours helpline was established on 1 July 2011 and there have been, as of 30 April this year, 500,410 calls handled.

Senator McLUCAS: Can you disaggregate those into years? Are they done on a financial year basis or on a calendar year basis?

Mr Booth: We should be able to. I do not think I have the figures by year with me. I just have the totals. I tell a lie—I do. In 2011-12, there were 154,592 calls; in 2012-13, there were 169,218 calls; and in 2013-14, up to 30 April, there were 176,600 calls.

Senator McLUCAS: So it is trending up?

Mr Booth: On those figures, yes.

Senator McLUCAS: Has any analysis of the effectiveness of the GP helpline been done to date?

Mr Booth: Healthdirect Australia, who run the GP helpline, have an ongoing process in terms of assessing consumer satisfaction and compliance and those kinds of things. They tend to do those as internal pieces of work to inform the helpline and how GPs are working and how the nurses are doing. They tend to do that pretty much on an ongoing basis.

Senator McLUCAS: That is not reported to you formally?

Mr Booth: I have not got a formal report on that, no—not for the after-hours GP helpline specifically.

Senator McLUCAS: Was it envisaged that there would be a formal review of the effectiveness of the GP helpline?

Mr Booth: I would need to take that on notice. There was certainly a review of Healthdirect Australia as a whole but not specifically of the helpline. I will double-check that to make sure I have got that right.

Senator McLUCAS: That is great. Thank you.

CHAIR: Are we there yet?

Prof. Halton: If I am bouncing up and down in the back seat, we probably are!

CHAIR: We will suspend now until 7.30. Is that suitable to everyone?

Prof. Halton: Extremely suitable.

CHAIR: Okay. Thank you.

Proceedings suspended from 18:29 to 19:31

National Mental Health Commission

[19:31]

CHAIR: We are resuming with Programs 5.4 and 5.5 and the National Mental Health Commission.

Senator McLUCAS: My first set of questions go to the review. We talked about this at last estimates. Mr Butt, you indicated that there would be some preliminary advice provided to government by 28 February and that there would be a second progress report in June. Can you update the committee on both of those events, please?

Mr Butt: The preliminary advice was very much about Commonwealth programs. We did work with various Commonwealth agencies on their programs and what they were spending, and I think I gave a bit of an outline at the time about the consultations and the 29 agencies we had been to. That was provided.

We are now very much in the process of providing an interim report by the end of June. We have been going through a bit of consultation on that. That includes a call for submissions, which I think you would have seen. We got 1,800 different submissions which we are now going through in terms of analysing them. We have had various meetings calling for further information. At the moment we are in the process of pulling together an interim report which we will get in by 30 June, but the final report is not due until 30 November.

Senator McLUCAS: So the first progress report was essentially a stocktake of Commonwealth-only-funded programs?

Mr Butt: Yes, a stocktake of Commonwealth-only-funded programs. Both of these are a sort of interim look at where we are at a point in time, building up to the final report which is due 30 November. It is not an unusual thing to give some preliminary advice on what we are doing in relation to a final report—but they are an input into the final report.

Senator McLUCAS: Was the first report published?

Mr Butt: No. It is a matter for government.

Senator McLUCAS: Minister, why was that not published?

Senator Nash: I would need to take that on notice.

Senator McLUCAS: It is just a statement of fact, really, is it not? A statement of what is being funded?

Mr Butt: Again, I would get back to the fact that this is an input into a final report. It is a collection of information and there are various things in it that we are still working our way through or we went back and asked for further information. Initially we went out to those 29 agencies, and 15 of them provided us with information about the different programs they are involved in and their level of expenditure. We have been doing further analysis on that. In a sense, a lot of what we are doing at the moment, and what we are going to be doing over the next few months, is to confirm that information and our findings out of that information. It is obviously an extraordinarily complex area in relation to the mental health system across Australia and looking at Commonwealth and state programs, non-government organisations, the private sector and the roles of consumers and carers and the like.

Again, that is one of the reasons why we went out for submissions and, as I said, we got 1,800. As a part of that, we wrote to 500 different peak organisations and NGOs. We asked them to ask their members and the others that they knew to look at the submission process and put in. We have subsequently gone out to 310 NGOs asking them for further detail on their expenditure. We are really doing a mapping process at the moment. It is very much draft information that we are trying to confirm and then draw some conclusions from that for our final report.

Senator McLUCAS: In terms of the first report, though, by publishing it you almost do a test of its accuracy because someone would read it and say, 'Hang on, I forgot about that; I need to tell you this.' Was that considered?

Mr Butt: As I said, it is a matter for government.

Senator McLUCAS: I understand. When you got the responses back from 15 of the 28 agencies that you asked for advice from, were there any holes—groups you thought you would get responses from that did not respond?

Mr Butt: 15 of the 29. No, we had a very high level of cooperation from the various agencies in terms of providing us with the information that we were seeking and we have again gone back to some of those agencies to seek further information. In fact, it is a reasonable mapping process to date. But we are, as I said, seeking further information from them—more detail, particularly on some of their expenditure areas in relation to NGOs.

Senator McLUCAS: The second report is due by the end of the month. Where the first report was a stock-take of Commonwealth funded programs, what is the flavour of the second report?

Mr Butt: The second report is an interim report again, as I said. It is a draft leading into a final report by the end of November. The second report is looking more broadly across the NGO sectors, the states, the private sector, trying to find out what expenditure is occurring and, obviously, relating back to our terms of reference about things such as effectiveness, efficiency, duplication, red tape, gaps in services, ways of doing things, how do we ensure we are contributing life, how do we focus the system on prevention, early intervention, recovery. So we are following the terms of reference very closely in what we are doing, and trying to draw directions from that.

Senator McLUCAS: You said 1,800 submissions were received?

Mr Butt: Yes, there were about 1,750 online submissions and we have also received close to 100 written submissions either by email or direct mail. They are still coming in. We had a cut-off date for the electronic submissions, but, in effect, what we have said is that we will continue to receive submissions. I think I got my latest one on Friday night, so they are still coming in and I expect they will continue to come in for some time.

Senator McLUCAS: For the online submissions, it was essentially a survey, as I recollect?

Mr Butt: It was a survey. It was based again on the terms of reference but done on the basis of a good research analysis of how you would go about a survey. About 300 of those submissions were from organisations and over 1,500 were from individuals. I thought that was a tremendous response.

Senator McLUCAS: Are there any themes emerging from analysis of the submissions to this point?

Mr Butt: It is really a little early to say. Because we asked questions along the lines of the terms of reference, what we asked for in many ways was: what is working well, what is not working, what should change? They were the three big themes. But they did follow the terms of reference in relation to effectiveness and efficiency, and the focus on things like workforce, prevention, Aboriginal and Torres Strait Islander people, rural and remote. So different organisations and individuals have responded on different terms of references. We have not finished the analysis. There is a lot of feedback, of course, on things such as Aboriginal and Torres Strait Islander mental health and the like. But it is too early to say what the analysis is really showing.

Senator McLUCAS: Okay. I dare say, if you are going to do a full analysis, therefore, of all programs and services provided to people living with mental illness, you will need a lot of information from the states and territories. Can you update the committee on what you are actually asking for from the states and territories?

Mr Butt: The sorts of things we are asking for from the states and territories again very much follow the terms of reference. We had initial responses from the states and territories, and think there is a high level of goodwill with the states and territories about what we are doing, from the commission's point of view. We are also dealing particularly with those states that have their own mental health commissions, which are Western Australia, New South Wales and Queensland, and there is a lot of work going on with those groups. We went back for more detail in relation to expenditure on NGOs because what we are trying to do is get a bit of a map of multiple funding bodies funding single organisations, often to do the same thing or to do slightly different things. We are trying to get a better picture of where you have that multitude of funders going to quite a large number of NGOs across the mental health sector. There are probably about 800 different NGOs working in the mental health sector, a large number of which are funded by the Commonwealth and a large number of which are funded by the states and territories, and there is quite a bit of crossover.

Senator McLUCAS: So you are asking the states and territories for data about expenditure?

Mr Butt: Yes.

Senator McLUCAS: What other data are you asking for?

Mr Butt: That is the main thing we have been asking for. Yes, that would be the main area, where we are asking: what is your expenditure? The thing we are asking everyone, really, is: what is the evidence of outcomes; where are the evaluations that you've done on the various programs in place; can you provide any evaluation reports, evidence et cetera that support the programs that are being funded at the moment.

Senator McLUCAS: You said you got an initial response from the states and territories. Was that from all states and territories?

Mr Butt: I would have to check that. I have a feeling that, from memory, two of them did not respond but I would have to check that. I will take that on notice.

Senator McLUCAS: Could you indicate which states did not respond?

Mr Butt: I will take that on notice.

Senator McLUCAS: You cannot recall that?

Mr Butt: No.

Senator McLUCAS: There aren't that many of them!

Mr Butt: Well, when you are getting 1,800 responses from your submissions and trying to work your way through them and all the other material that is coming in—there is quite a bit of material that we are working our way through.

Senator McLUCAS: Give the committee of flavour, if you would, of the preparedness of states and territories to provide their pieces of evaluation work.

Mr Butt: Again, it is probably a little bit early to tell because what we are looking for is evidence that will feed more into the final report. I am working with each of the states and territories individually. I have been working with the Mental Health and Drug and Alcohol Principal Committee of AHMAC as well on what access we can get to data, performance information, National Mental Health Service Planning Framework information and those sorts of things, and those are ongoing discussions. So it is probably a little bit early to tell where we are

going to end up on that. I am not trying to get all of that by 30 June, to be very clear. We are entering the countdown now to finalising the next response, the next interim report. That will feed more into the next report.

Senator McLUCAS: So it will not be a comprehensive interim report?

Mr Butt: No, no, and it was never intended that it would be a comprehensive interim report. It was really about where we are up to and what sort of flavour we are getting—what directions we are going in in relation to the information we are getting.

Senator McLUCAS: So all states and territories are providing you with timely information and the data on expenditure?

Mr Butt: Again, as I said, I would take that on notice and get back to you.

Senator McLUCAS: No, my first question was around the initial response to the first, I dare say, letter—a letter was written?

Mr Butt: Yes.

Senator McLUCAS: Then you went back to—

Mr Butt: A letter and a template.

Senator McLUCAS: Then you went back to the states and territories.

Mr Butt: Yes.

Senator McLUCAS: So there was a template for them to fill in?

Mr Butt: Yes.

Senator McLUCAS: Would it be in order for the committee to have a look at that? That would give me an understanding of what the scope of the work you are doing is.

Mr Butt: Sure. That should be no problem.

Senator McLUCAS: Are all states providing data on expenditure in a timely way?

Mr Butt: We are only now into that process, so we have not finished it. As I said, I am also going through the Mental Health, Drug and Alcohol Principle Committee of AHMAC and talking to them about that access, and then doing individual consultations with the different states and territories on access to that data. As I said, I do not need all of that by 30 June; I need what access I can get to data. I am not suggesting for a moment that I am going to get a comprehensive picture from each state and territory on their expenditure. There are issues that they have raised with me, for example, about contracts that they have entered into which are commercial in confidence, which is not unusual when you go out to processes where you are actually using tender processes or whatever it might be.

Senator McLUCAS: You are not asking for the name of the person who was successful in gaining a contract?

Mr Butt: Ideally that would be excellent. Again, if you get back to the issue of looking at different funders funding the same agencies to do similar things, that would be very useful information. But yes, obviously there is a lack of desire to provide that type of information.

Senator McLUCAS: What do you put that down to, other than the commercial in confidence.

Mr Butt: Confidentiality. It is a commercial process. They have processes where they go to tender, they award contracts and the details of those contracts are not necessarily made available.

Senator McLUCAS: Are they giving you the overall global expenditure on a certain program in their budget?

Mr Butt: In the initial response they gave us the overall global expenditure in a whole range of areas, and we also get a lot of that through the report on government services and the data that is provided to the Australian Institute of Health and Welfare. We work with the ABS as well on how we match that up with census data and so forth. Initially we got quite a reasonable amount of data from those different sources, but it is this next level down where you are actually trying to do that matching which is much more sensitive.

Senator McLUCAS: By next estimates we might have some greater clarification about the second report, I imagine. In terms of other work that the commission is undertaking outside of the review, do you have a work plan that shows those activities?

Mr Butt: We do, yes.

Senator McLUCAS: Is that published or available to people?

Mr Butt: It has been published, yes. It has been available for a while. We are in a process now of looking at updating it, but it has been held off pending the rush of work that we have got to get done over the next few weeks. But yes, there is a document about our work plan and strategic plan.

Senator McLUCAS: So that is not up to date? I am not being critical at all, Mr Butt.

Mr Butt: It is reasonably up to date about the projects that we are doing. Obviously we have got a change in emphasis, because we have been tasked to do this particular review this year, but the projects that we were doing—whether it was on contributing life or seclusion and restraint or mentally healthy workplaces and so forth—are all listed in there and we are progressing those things.

Senator McLUCAS: I think you have told the committee before that this review will essentially replace the report card.

Mr Butt: We are not doing the same sort of process that we did for previous report cards, albeit that the two years of work that went into developing the two report cards is forming the foundation of the review that we are doing, because we obviously got a lot of feedback and information from that that we are using. We are also using the projects. Things like mentally healthy workplaces is obviously a major issue in relation to the Australian mental health system and the review, as are things like seclusion and restraint and the work we are doing on that. That will all feed in to the review.

What we will also be doing is an update by the end of the year on progress against the 18 recommendations in the report cards from 2012 and 2013. So it will not be a new report card, but it will be an update on progress.

Senator McLUCAS: Can you explain to the committee your methodology of assessing the effectiveness of programs that may be delivered—both Commonwealth or state and territory?

Mr Butt: That gets back a bit to what I was saying about the ability to do evaluation and to get evidence about what works and so forth. Like a lot of things—and certainly not just in mental health—there is a lack of substantial evaluation evidence about a lot of the things that happen within mental health, as well as more broadly. Our methodology is to look at whatever evidence or whatever literature there is. We have done literature reviews nationally and internationally trying to get evaluation reports on specific programs. You can apply a lot of principles to things and say that, if you apply those principles to particular programs and they are an agreed set of principles, then you can actually make assessments on areas where you should be focusing, following your policy leads and doing your investments. However, it is much harder to say, 'On the basis of the evidence that is available, we should be funding X but not Y.' It is a more principled approach. Where there is evidence available, obviously we will be using, explaining and presenting that, but that is not necessarily connected to individual programs; that is connected more to particular areas of focus, such as prevention, early intervention, recovery, workplace participation, housing, relationships et cetera.

Senator McLUCAS: Do you use population-based data?

Mr Butt: Yes. We are using a population-based life trajectory approach. We are looking at different population groups and using what information we have that is available in relation to different interventions or approaches. We are looking, for example, at early childhood, what happens with youth, what happens with older people and what happens with aged people. We are then also looking at a segmented approach in relation to the different things that might happen through that life course. For example, we are getting economic modelling done on things such as what happens to a 14 year old girl with eating disorders through the course of her life, what is the likely trajectory, and, taking into account that trajectory, what are the likely costs to the system. We then multiply that out on a population basis and say whereabouts throughout that life course could you have interventions that would make a difference to the outcomes for that person and the costs to the system—so if you invest upstream, what do you save downstream.

That is just an example, and we are using quite a few examples of that, which we then extrapolate out on a population basis. Another example would be a youth hitting the juvenile justice system: what do they cost to the system if you follow them and what happens to them individually, and to their supporters and carers, if you follow them through their life as they stay within the justice system.

Senator McLUCAS: Have you tried to link any of the population data at all—whether it be MBS, PBS or DHS data?

Mr Butt: We are currently looking at a data linkage project, which we are working up. As you would be aware, it has not often been agreed that these sorts of thing go ahead, but we are working on a data linkage project which is looking at using de-identified MBS and PBS data and matching it with ABS census data on a collection basis, which would give a reasonable profile of the types of people who are accessing the MBS for certain items

for certain treatment and certain medication. So yes, we are looking at a data linkage program there, but it has got a bit of way to go in terms of ethics approvals and so forth.

CHAIR: Sorry, can I just clarify something? Is this a typical person with an eating disorder or a typical person involved in youth justice?

Mr Butt: That is a different part of it.

CHAIR: That is not qualitative research?

Mr Butt: That is actually an economic modelling exercise, which is separate to the data linkages.

CHAIR: A genuine modelling exercise, Mr Butt.

Mr Butt: Yes, but that is separate to the data linkage program.

CHAIR: I realise that. Before you moved on I just wanted to just clarify that.

Mr Butt: It is using about 10 different models, which have been worked out with a range of people—psychiatrists, psychologists et cetera—within the mental health system.

Senator McLUCAS: Have you let any contracts for work as part of the review?

Mr Butt: We have. The contracts that have been let have been in relation to the economic modelling project and a research project. We are also looking at a workforce project, an Aboriginal and Torres Strait Islander project and a new and emerging technologies project. We have not finalised most of those, but we have certainly finalised the economic modelling project.

Senator McLUCAS: Has that been posted on the contracts website? If it has, I have missed it.

Mr Butt: I would have to check that, so I will take that on notice. If it was on a website, it would be on Prime Minister and Cabinet at the moment.

Senator McLUCAS: Yes, that is the one we would go to. On notice, Mr Butt, could you provide us with—if they have not been let, you cannot do this—once they are let, what contracts have been let to whom and what the purpose of each was? That was done off the preferred tenderer list rather than going out to general tender for these contracts?

Mr Butt: That is right—given the time frames we had. The other contracts we have are standing contracts with AIHW and the ABS, because of the work they do with us. They worked with us on the report cards as well, which feeds into this.

Senator WRIGHT: In tasking the commission with the review, did the minister request the commission or the department to compile a list of past inquiries into mental health and their recommendations—to avoid duplication?

Mr Butt: The minister did not request it of us, but we have done that. We have done an assessment of what reviews have been done and what recommendations have been made. That was part of our literature search. I think that has been one of the issues, of course—that there are a lot of reports and recommendations that do not necessarily align.

Senator WRIGHT: On that, can you tell us how many federally funded reviews and inquiries into mental health there have been in the last decade?

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

Senator WRIGHT: Can you give us a ballpark figure?

Mr Butt: No, I could not.

Senator WRIGHT: There are so many. There are lot. I think everyone understands that this is a very reviewed and inquired into area.

Mr Butt: There have been reviews but also plans and road maps. There have been a whole range of things. It depends, at the end of the day, what you call a review. There have been reports on specific aspects and there have been broad reports. There have been mental health plans, there have been road maps, there have been state level—

Prof. Halton: There has been an awful lot of analysis.

Senator WRIGHT: I do not know about the emphasis on 'awful', but certainly there has been a great deal.

Prof. Halton: Let me rephrase that. There has been a very large amount.

Senator WRIGHT: I was only teasing. If you could tell me the number, that would be good.

Mr Butt: We have certainly taken that on notice.

Senator WRIGHT: Minister, given that consideration of various mental health programs and so on, as we have already heard today, has been deferred in this budget pending the outcome of the review, how will the commission's report influence government funding of mental health into the future? I am interested in knowing what the process will be once the report is received.

Senator Nash: I will take on notice the exact detail. But certainly the government's expectation is that we will be very well-informed by what will obviously be a very detailed review of the sector, as is necessary and appropriate. I think there is a lot of work being done by the commission that will be very valuable in informing the government's way forward.

Senator WRIGHT: I am asking about the funding. Is it possible that the government will receive the review and think, 'Gosh, there is a lot of good work happening with these programs, and indeed gaps have been identified where more funding would be a very good idea.' Is that possible or is it more likely that the government will say, 'No, there will be no more funding available; there will be less funding available.' That is what the public really wants to know.

Senator Nash: That is a very hypothetical question and I would not like to pre-empt the work the commission is doing. We will be waiting for the report.

Senator WRIGHT: You cannot really say anything except that the government will look at the report when it comes out.

Senator Nash: That is right and I think that would be the expectation. I do not think anyone would expect the government to pre-empt the findings of that or make any indications as to what the view would be prior to receiving the report.

Senator WRIGHT: No, but it is not unfair to suggest that, given that there are a lot of people who would say that mental health funding generally is underfunded relative to its burden of disease, the government could be saying, 'Look, we want to spend more but we want to know how best to spend that money and what programs are, on the basis of the review report, the most efficacious.' You are not willing to say that, I guess.

Senator Nash: There are various views for various reasons, and that is precisely why we have commissioned the report—to be well-informed.

Senator WRIGHT: There is also speculation that the government is actually emphasising efficiencies and duplication in order to justify making less funding available to mental health in the future.

Senator Nash: I really do not think it is appropriate to make any commentary until we let the commission do its work. They are obviously doing that in a very thorough and diligent manner, and we will make commentary once we receive the report.

Senator WRIGHT: Will the 2015 budget detail mental health funding over the forward estimates or will services be funded only year to year?

Senator Nash: I certainly could not comment on next year's budget.

Senator WRIGHT: Can I come back to you, Mr Butt, please. What funding and staffing changes have occurred in the commission over the past 12 months?

Mr Butt: Our budget this financial year has funding of $6.4 million for departmental and administrative; next year it has $6.5 million. So it has not really changed much, as you would expect. We have a staffing allocation of 13. At the moment my FTEs are 10 because a couple of people have left. I would have to go back and check in order to give numbers who have gone and come, so I would have to take that on notice. It is just normal and coming and going—for example, Deputy CEO, Georgie Harman, went to take over as CEO of beyondblue, so that was a recent gap that occurred. We are also getting some assistance from the department, so I have two people on secondment at the moment and I am also getting some support from using five people in the business services centre of the department for the analysis of the large number of submissions that overwhelmed us somewhat, so that has been good. I have not asked for additional funding or additional support above that.

Senator WRIGHT: Are those two additional people from the department and those five people in terms of managing the submissions and so on part of the staffing of 13 FTE?

Mr Butt: No. At the moment are FTEs are 10. The five are not permanently on this; it is only short-term, so it is not a full-year effect. The full-year effect is quite minor. So, no, they are not part of that. The decision by government was to give us the level of support that was required to get the job done and my assessment at the moment is that what we need at the moment is that sort of staffing support from the department. As I say, the BSC role there in relation to the analysis is short term; other roles might be longer term.

Senator WRIGHT: Given the Commission of Audit's findings generally, is it anticipated that the commission will continue to exist in its current form over the forward estimates?

Mr Butt: That is a matter for the government, not for the commission.

Senator WRIGHT: I should have directed that to the minister. Minister, given the Commission of Audit's general findings, is it anticipated that the commission will continue to exist in its current form over the forward estimates?

Senator Nash: I will need to take that on notice for you.

Senator WRIGHT: Butt, to what extent has the commission considered the National Mental Health Services Planning Framework, which was completed in 2013, in its review of mental health services?

Mr Butt: We do not have access to the National Mental Health Services Planning Framework; that sits with the Commonwealth and the states and territories.

Senator WRIGHT: Have you sought access to that?

Mr Butt: Yes, we have.

Senator WRIGHT: Can you explain why you do not have access to that?

Mr Butt: I think that would be a question for the department.

Senator WRIGHT: Perhaps I will come to the department then, because my understanding is that the framework took two years to complete, originated in COAG and was coordinated by New South Wales Health and involved dozens of senior people from the sector. So it would seem to me very logical that that framework would be at least available for consideration in terms of the thorough review that the commission is undertaking. Can I ask the department why the commission would not have had access to that National Mental Health Services Planning Framework? It would seem very logical material for them.

Mr Booth: The National Mental Health Services Planning Framework was a framework that was done through all jurisdictions and all jurisdictions needed to agree and respond in order to do that, and that has not been the case.

Senator WRIGHT: So, who has not agreed then, Mr Booth?

Prof. Halton: It has not come forward to the multilateral forum for endorsement, because of the technical work. My understanding is that a number of jurisdictions had some issues with it and it has not come forward for ministerial endorsement.

Senator WRIGHT: Is my information that it is completed wrong, then? Is it not actually completed or is it completed?

Prof. Halton: It is not endorsed. Some of the people who worked on it might think it is completed, but until it is endorsed by all jurisdictions it is not completed.

Senator WRIGHT: What are the jurisdictions that have not endorsed it at this stage?

Prof. Halton: I cannot answer that question. I am sorry.

Senator WRIGHT: When you say you cannot, do you mean that you do not have the information available?

Prof. Halton: No, I do not know.

Senator WRIGHT: Can you take that on notice?

Prof. Halton: Absolutely.

Senator WRIGHT: It just seems to me that is we are having a serious, serious review on which presumably programs are going to rise or fall and funding will presumably be allocated into the future—that is certainly the picture that I am hearing—so it would seem really logical to take advantage of huge amount of work that went into that as well.

Prof. Halton: Yes. Although, I have some passing familiarity with this and I would say that my observation of it—from a distance—was that it was drawn up by people in and of the sector, without a broader grasp on broader approaches. That meant that it was a little self-referencing.

Mr Butt: From the commission's perspective—while it would be good to get access to it—there is not much point getting access to something that has not got broad support, because it would not have credibility. There is not much point us pursuing that until the states and territories are comfortable that what they would be giving us is a good product.

Senator WRIGHT: I can understand that. I am just imagining that there is a research basis to some of the framework that would be potentially useful as information for the commission. Anyway, the question has been taken on notice for me.

Senator McLUCAS: Is this framework an item on the ministerial council or standing committee—whatever it is called; the new name for the ministerial council.

Prof. Halton: No.

Senator McLUCAS: When was it last on the agenda of the ministerial council?

Prof. Halton: I would have to take that on notice as well. I am not sure that it has ever actually been to the ministerial council, precisely because of the issues that I just referred to. I think it has not made it.

Senator McLUCAS: Who asked for the work to be done? Which entity was it?

Prof. Halton: My memory will fail me on this. I will have to take the history of this on notice.

Senator McLUCAS: When did that happen and what was the procedure by which it was agreed to progress the work?

Prof. Halton: Yes.

Senator McLUCAS: How did New South Wales become the lead entity?

Prof. Halton: That is in the mists of time. We are happy to go excavate, but I cannot answer the question now.

Senator McLUCAS: What was proposed to be the approval mechanism? Was it through the ministerial council or was it through another form? I am asking you to take that on notice.

Prof. Halton: We will.

Senator McLUCAS: Can I go back to staffing. I am not sure that I did followed Senator Wright's questions and your answers accurately. In February, you told me that the full-time equivalent of the commission was 12.6.

Mr Butt: Yes.

Senator McLUCAS: I think you have said that the current FTE is 10.

Mr Butt: That is right.

Senator McLUCAS: And that there are some vacancies.

Mr Butt: That is true.

Senator McLUCAS: How many vacancies?

Mr Butt: On that basis, there would be three FTE vacancies. Sorry, 2.6 vacancies.

Senator McLUCAS: That is what I am trying to ascertain. Are there actual vacancies?

Mr Butt: I would have to break it down, because I do not have a list of people who are working 0.3, 0.2 or whatever it might be.

Senator McLUCAS: Then you told us that there were five people from the business service centre on top of that.

Mr Butt: There are five people who are assisting us with the analysis of the submissions on a temporary basis. That is a short-term project.

Senator McLUCAS: They are on top of your current staff?

Mr Butt: They are on top of our current staff as well, yes. That is because we are not paying for those, as such. The department is paying the cost of those people. It is a short-term thing. It is not like five over 12 months equals five FTEs.

Senator McLUCAS: What is the staff turn-over rate at the commission?

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

Senator McLUCAS: I would like now to go to the minister's media release on Friday 4 April, which is not to the commission. It is to the department.

CHAIR: Does anyone else have any other questions for the commission, before we move on?

No. We will move on.

Senator MOORE: Mr Butt, you said earlier that this year we will not be getting the standard report from the commission—I am trying to think of the right term.

Mr Butt: Report card, yes.

Senator MOORE: The report card. When it was set up, that was one of the basic processes that were negotiated between the government and the community—about how it would work, the operational process—but there will just be an update this year. Has there been much discussion about that with the consumers of that report card? They are far and wide, the people who want to read that.

Mr Butt: Yes. I have done quite extensive consultation with the community—consumers, carers, providers, NGOs—and I have been making it clear all along that we have now been tasked with a particular project which we have to run in a particular way, so we will not be doing the report card the same as we have in previous years. So I think it is reasonably well understood.

Senator MOORE: But is it only for this year because of other work pressures, or is this a change in approach?

Mr Butt: As far as I am aware, it is an issue for this year, but I cannot forecast what is going to happen next year.

Senator MOORE: No-one can. I wish we could, but no-one can. It was just that I am aware of the quite personal sense of ownership of that process that has built up across a lot of our community. That report card has become an important kind of document. My understanding was that it was only for this year, but I just wanted to get that clarified.

Mr Butt: As far as I am aware, that is right.

Senator MOORE: Okay. Thank you.

Senator McLUCAS: The health minister issued a media release on 4 April announcing $170 million for the continuation of 150 mental health programs during 2014-15 while the review is underway. Can I get an understanding of those 150 programs? What does the word 'program' mean in that context?

Mr Booth: Those would be specific mental health programs, so they include the areas we were discussing earlier, before dinner, around ATAPS, mental health programs around suicide prevention, e-mental health programs—all of the mental health programs that we run. The decision was made to continue funding for a further 12 months, until the results of the review were known.

Senator McLUCAS: Mr Booth, because of the way the word 'program' has been used in that press release, I think I might be taking a view that may not be accurate. Are we talking about 150 contracts with services?

Mr Booth: No. They would be programs, and those programs could have a number of contracts underneath them. They are specifically mental health programs.

Senator McLUCAS: Is there a list of those 150 that I could have, please?

Mr Booth: I am sure we could do a list of mental health programs, certainly.

Senator McLUCAS: Thank you. And the number of contracts that sit under those programs? Is that possibly something that we could be supplied with?

Mr Booth: It is something we could take a look at, yes.

Senator McLUCAS: Can you provide me with the names of the successful providers of the services under those 150 programs?

Mr Booth: I would need to have a look at the amount of information that would involve. Certainly, we can get you the names of the programs. For example, ATAPS, as we were discussing before, is run through Medicare Locals, so one program will have a number of contracts underneath. But some of the other programs are run by quite small organisations across the country, so we would need to have a look at that. But we will take a look.

Senator McLUCAS: Thank you. Quite a number of organisations and entities have also had difficulty trying to understand what '150 programs' is, including our Parliamentary Library, so I think a lot of people would be interested in knowing what it is. Does the funding provided in 2014-15 include indexation from the 2013-14 year?

Mr Booth: I would need to double-check that.

Senator McLUCAS: Okay. If you could, that would be great—and what type of indexation it is.

Mr Booth: Yes. We will take a look.

Senator McLUCAS: For two estimates now, I have been asking for an understanding of a number of programs and I have a recent answer to a question on notice that says that it is not proper for me to know this. It says:

Information on unpublished and uncontracted funding is not normally provided as this information can be misleading.

I am not asking how much you are giving to St Vincent's in Canberra; I am asking for these top-level programs over the forward estimates. I find that answer hard to understand. Why is that the answer, Professor Halton? It is No. 266.

Prof. Halton: I am aware of it. That is the answer.

Senator McLUCAS: Why is it that I can go to the Department of Infrastructure and ask them what the forward allocation of money for a bridge over a creek on the Bruce Highway is and they will tell me? Why can't we do that in this department?

Prof. Halton: The creek is known and the bridge is known. In this case, these things are not known. There is a concern inside government that it will be misleading.

Senator McLUCAS: But there is money in the budget allocated for the Mental Health Nurse Incentive Program for 2013-14, 2014-15, 2015-16 and 2016-17. Why can we not know, at that level, what the allocation of money in the budget is?

Prof. Halton: There is nothing more I can add to my answer.

Senator McLUCAS: Why is it misleading? It is in the budget. It has been appropriated for those years—misleading to whom? It is a figure.

Prof. Halton: It is traditional practice over many years not to provide that level of detail. It is the certainly the view, in this context, that to provide that level of detail is potentially misleading.

Senator McLUCAS: To whom?

Prof. Halton: To whoever might read it.

Senator McLUCAS: If there is a figure, for instance, in 2014-15 for the Mental Health Nurse Incentive Program of $25 million, let us say—how can that be misleading? It is a fact. It is a figure in a line of the budget.

Prof. Halton: It is not a line in the budget because it is not published.

Senator McLUCAS: It is correct that it is not published, but it is a line in your budget. How can that be misleading?

Prof. Halton: It assumes that every cent in that context will be spent—and that is not guaranteed. These are uncontracted at this point. I cannot add to this answer.

Senator McLUCAS: Let us work backwards. The first time I asked you the question, you told me that the funding for the Mental Health Nurse Incentive Program, for 2013-14 to 2015-16, was $81.55 million. How much was allocated in 2013-14?

Mr Booth: The budget for 2013-14 was $41.8 million.

Senator McLUCAS: And for 2014-15?

Mr Booth: The budget for the Mental Health Nurse Incentive Program for 2014-15 was $41.7 million.

Senator McLUCAS: There are no funds in 2015 16?

Mr Booth: There was funding within the budget for $22 million this year. That was funding to keep the services at the current levels. That has been the case for the past two budgets, I think.

Senator McLUCAS: I am not following you now. I thought you said 2013-14 was $14.8 million.

Mr Booth: That includes additional funding that was made in 2013-14, because there was a top up to the funding to maintain services at that level. That is the same thing that has happened within this budget.

Senator McLUCAS: In 2013-14, there was an extra $20 million, you were saying?

Mr Booth: In the 2013-14 budget there was $20 million. Yes, it was a similar figure.

Senator McLUCAS: So the total was $63.8 million.

Mr Booth: No, the total was $41 million. That is the figure that I have given you.

Senator McLUCAS: But with an extra $23 million.

Mr Booth: That was in last year's budget.

Senator McLUCAS: Explain to me the $41.7 million in the 2014-15 budget.

Mr Booth: Again, an extra $22 million has been put into it to maintain services as current levels. I think this is a measure that goes back a number of years. In the past two years, there has been that top-up funding of $22 million to maintain services at current levels.

Senator McLUCAS: The actual amount that would have been shown in the budget was something like $20 million, with the extra $20 something million top up.

Mr Booth: $22 million for the top up, which would have given that total in the budget.

Senator McLUCAS: For me to make sense of your question on notice E13.156, which says that funding for the program totalled $81.55 million from 2013-14 to 2015-16, how do I fill in the column that says 2015-16 for the Mental Health Nurse Incentive Program? If you are saying that $20 million was allocated for 2013-14 and $20 odd million in 2014-15, that is about $40 million spent out of the budgeted amount. That means there is about $40 million left in 2015-16.

Mr Booth: I am just saying that what happened in this budget was that there was an additional amount of $22 million put in to maintain services at current levels. That was the same as was done in last year's budget as well, to maintain services at those levels.

Senator McLUCAS: Are you telling me that essentially that money has been spent? There is no more money in that program that you indicated had $81.55 million over 2013-14 through to 2015-16.

Mr Booth: No, what I am saying is that funding for 2014-15 has been maintained at current levels, so that services for 2014-15 can continue to be provided.

Senator McLUCAS: How much should I put in the column that says 2015-16?

Mr Booth: I do not know, because that again depends on that top up in terms of service levels. I do not know what would happen.

Senator McLUCAS: On the National Perinatal Natal Depression Initiative, how much was allocated in 2013-14?

Mr Booth: For that one, in terms of state and territories' funding for 2013-14, there was $10.8 million. Beyondblue also obtained funding of $500,000 and there was ATAPS funding of $5 million.

Senator McLUCAS: And in 2014-15?

Mr Booth: In the current budget, we have $8.2 million for the states and territories' funding. Again, $500,000 for beyondblue and $5 million for ATAPS.

Senator McLUCAS: In your first answer on notice, you told me that $27.2 million was allocated to that. I can extrapolate that the residual funds out of that $27.2 million could go in the 2015-16 column?

Mr Booth: As with other programs that we have been discussing, the funding is there for 2014-15, for next year, for 12 months and will be looked at in the light of the Mental Health Commission's review.

Senator McLUCAS: Is that why it could be misleading, Ms Halton—because everything is going to change?

Prof. Halton: Sorry?

Senator McLUCAS: Is that why it could be misleading—because everything could change?

Prof. Halton: I cannot comment. We do not have any decisions in this space. There are sorts of reviews going on in this space, and I think the concern is that any information provided could potentially be misleading. That is all I can say.

Senator McLUCAS: I will come back to it at another time. In terms of the Partners in Recovery deferral—I would call it theft—of $53.8 million from the 13 remaining services that are yet to roll out, there is a line in the budget that says:

This deferral will enable the effectiveness of the existing sites and their interaction with the National Disability Insurance Scheme to be assessed.

Can I get some understanding of what engagement has occurred to date with the National Disability Insurance Agency about the Partners in Recovery program and future arrangements?

Mr Booth: At a very high level, Partners in Recovery is being looked at in terms of some of the pilot sites for the NDIS, and we will be awaiting what happens as a result of that pilot. The policy decisions are not within my area, within the Department of Health.

Senator McLUCAS: In which part of the Department of Health are they being managed?

Mr Booth: No, I mean the actual running of the NDIA itself is not, so we do not have a policy around that.

Senator McLUCAS: No, it is not in your department at all.

Mr Booth: No, that is right. So we would not do the policy around that. There have been discussions around Partners in Recovery and some of the funding, and that is still under discussion and being looked at in terms of the pilot sites for the scheme.

Senator McLUCAS: So are there any conversations between Department of Health officials and the NDIA around how Partners in Recovery will interact with the NDIS?

Prof. Halton: We still have a number of questions about the relationship between our programs and the NDIS on which I do not have clarity at the moment. Dr Bartlett has coordinating responsibility, under David Learmonth, in the department for trying to determine some of those issues. But it is fair to say that we have been unable in some areas to get answers to some of the questions. Now, that is probably just a function of where things are up to in terms of the development process. Certainly, Mr Booth cannot answer the specifics of the question. But it is being coordinated through Dr Bartlett.

Senator McLUCAS: Okay. So there has been no work done that would give an assessment of the number of consumers who are receiving support through Partners in Recovery who may be eligible for NDIS type packages? No-one has done any of that work?

Prof. Halton: It is really the other way around, as I understand it. It is more that there were expectations that some programs—this is under the previous government—would be rolled into the NDIS, and we have been seeking clarity about on what basis that might occur and in respect of which clients, and that is the thing which we do not have an answer to.

Senator McLUCAS: So what do we plan to do to find out the answer?

Prof. Halton: We are attempting to get the answer and we have been raising it with the relevant department—in fact, I was talking to Mr Learmonth about this only a matter of days ago—but, as yet, some of those questions remain unanswered.

Senator McLUCAS: Okay. We will put that on the agenda for next time.

Senator MOORE: Can I follow up briefly on that one. Is there a formal communication process between Health and the NDIS agency? Is there something that clicks in on that?

Prof. Halton: No. That is possibly one of the weaknesses.

Senator MOORE: Okay. We will check with NDIA, but it seems to me that the whole structure, the way the place operates, is about having those formal links that have to be ticked off.

Prof. Halton: Yes, which is why I have tasked Dr Bartlett with trying to get to the bottom of it.

Senator MOORE: Okay. Thanks.

CHAIR: Senator Wright.

Senator WRIGHT: I would like to follow up with some more questions about the Mental Health Nurse Incentive Programme. The Royal Australian and New Zealand College of Psychiatrists have questioned why the budget shows that funding for the program is only continued for 12 months. Does the program have ongoing funding over the forward estimates?

Mr Booth: The answer to that is as for those previous ones—the funding has been put forward for the next 12 months and will be considered in light of the findings of the Mental Health Commission review.

Senator WRIGHT: I got the impression that Senator McLucas—I was listening carefully to that—was asking for funding for the 2015-16 year.

Mr Booth: And we were giving the 2013-14 and 2014-15. I am saying that from—

Senator WRIGHT: Yes, that is right. That is actually subject to the review.

Mr Booth: That is right. The funding is guaranteed for 12 months but in light of the commission report.

Senator WRIGHT: Will the GP co-payment impact patients seeing a nurse through the minute program?

Mr Booth: I cannot really comment on the patient co-payments. Again, that is another outcome area; I would need to take that on notice.

Senator WRIGHT: Could you take that on notice for me, please?

Mr Booth: Yes.

Senator WRIGHT: Did the government consult at all with the mental health sector or consumers about the possibility that a co-payment would discourage people with a mental illness from seeking help?

Mr Booth: Again, I cannot comment on that.

Senator WRIGHT: Perhaps I could ask the minister's representative here.

Senator Nash: That is a budget matter.

Senator WRIGHT: No, it is a question—

Senator Nash: Hang on, let me finish. It is a budget matter, but insofar as I can I will take it on notice and try and provide you with an answer.

Senator WRIGHT: It is a very legitimate question. Again, we can say that governments can choose to charge anything they like, but we are in the mental health estimates and there is accepted wisdom that early intervention or prevention is optimal when it comes to health—but particularly mental health; it is not really controversial—and obviously people are interested in knowing if there is a possibility or a risk that a co-payment will prevent people from seeking that help early. Was there any consultation about that measure before it was decided upon in terms of this area of health? That is what I am asking. Also, will the co-payment be charged for mental health items such as the GP mental health care plan and reviews of the care plan?

Mr Booth: Again, I would need to take that on notice and raise it with colleagues in the MBD area.

Senator WRIGHT: So you do not know the item numbers that would be applicable?

Mr Booth: I would rather take that on notice, because it is not an area that we look after. The co-payments has been looked at within another area of the department.

Senator WRIGHT: Is the minister's representative able to shed any light on that?

Senator Nash: Not the specific detail. I would not like to make an assumption, so we will get you the actual detail on that.

Senator WRIGHT: What is the total funding for the Mental Health Nurse Incentive Programme was in 2012-13 in terms of what was actually spent?

Mr Booth: The total allocation in 2012-13 was $39.689 million.

Senator WRIGHT: We have heard about the budget allocations for 2013-14, but what is the expected expenditure for the program?

Mr Booth: Again, it would be a very similar amount, because what has happened is that funding has been available to maintain services at current levels, so the funding would be expected to be very similar.

Senator WRIGHT: Similar to the previous figure you gave just then—$39.689 million?

Mr Booth: Yes.

Senator WRIGHT: I will ask for this on notice, given the time constraints. How many sessions were claimed in each financial year from 2007-08 to 2013-14 inclusive?

Mr Booth: We would not have that for 2007-08. We will take that on notice.

Senator WRIGHT: How many actual sessions were allocated in 2012-13 and 2013-14? If you have those figures now, that would be useful.

Mr Booth: In 2013-14 there were a total of 150,079 sessions currently allocated to 383 organisations.

Senator WRIGHT: They are called 'eligible organisations'—is that right?

Mr Booth: Yes.

Senator WRIGHT: What about the preceding year?

Mr Booth: In 2012-13, approximately 160,000 sessions were allocated.

Senator WRIGHT: Why is that only approximate?

Mr Booth: I would need to double-check, but 160,000 is the figure I have in terms of allocation.

Senator WRIGHT: Do you have the number of eligible organisations the sessions were allocated to?

Mr Booth: Not a total number, no. I would need to take that on notice.

Senator WRIGHT: If you could double-check that figure of 160,000, though it seems absolutely precise.

Mr Booth: I will do that—that is the allocation.

Senator WRIGHT: And the total number of eligible organisations. How many will be allocated for 2014-15?

Mr Booth: We are looking at up to 165,000.

Senator WRIGHT: Thank you. How many organisations are currently registered as eligible organisations for the MHNIP?

Mr Booth: That would be around about the number I have just given to you, which was 383. I will take that on notice, but I would say 383.

Senator WRIGHT: Again on notice, how many organisations were registered as eligible organisations at the outset of each financial year from 2007-08 until 1 July 2013? How many nurses have delivered services under the MHNIP between 1 July 2013 and the current date?

Mr Booth: I will need to take that one on notice as well.

Senator WRIGHT: Similarly, on notice, how many did so in each previous financial year from 2007-08 onwards?

Mr Booth: Yes.

Senator WRIGHT: How many individual patients received services under the program from 1 July 2013 to the current date?

Mr Booth: Again, we will take that on notice.

Senator WRIGHT: You do not have any figure there that could help me at all? Just so I have a sense without having to wait for the answer—you can always check it.

Mr Booth: No, I would need to take that on notice.

Senator WRIGHT: Similarly, how many were there in previous years from 2007-08 onwards? I would like to know the average number of times a patient is seen in terms of sessions attended or claimed under the program. I have looked extensively at the program and it comes highly recommended from many people, so I am interested in knowing exactly who is being attended to by it.

Mr Booth: Yes, absolutely.

Senator WRIGHT: Can I go to questions about suicide now, please. The rate of suicide in Australia appears to be rising, and I am interested to know to what extent the government considered the 42 recommendations in *The hidden toll* report, which was the report of a Senate inquiry by this committee into suicide in 2010.

Mr Booth: I would need to double-check in terms of the formal recommendations on that and what the response was to that.

Senator WRIGHT: You are not aware of any recent discussion or consideration of those recommendations?

Mr Booth: About the recommendations of that particular report, no, I am not.

Senator WRIGHT: One of the many recommendations which have not been implemented, but which is also advocated for by suicide prevention experts, is a target for suicide reduction. Has the government considered this?

Mr Booth: I do not know.

Senator WRIGHT: Has the current government considered this?

Mr Booth: That would be a question for the government.

Senator WRIGHT: I thought maybe you were aware of something that the department had been asked to look at.

Mr Booth: Targets? No.

Senator WRIGHT: Could I ask the minister's representative—has the government considered that?

Senator Nash: I am not aware, but I am very happy to take that on notice.

Senator WRIGHT: I am interested to know what implications the 2014 budget has in relation to suicide prevention commitments over the forward estimates.

Mr Booth: Again, it is the same answer as previously. The programs under the National Suicide Prevention Program and the Taking Action to Tackle Suicide package are continuing for the next 12 months, and funding is continuing until the—

Senator WRIGHT: Pending?

Mr Booth: Yes, until the review has been completed.

Senator WRIGHT: Okay. I turn to youth mental health. I would like to acknowledge the funding in the budget to expand headspace and to establish the Centre of Excellence in Youth Mental Health, which implements coalition election promises. Has the government considered to what degree those measures, worthy as they are, are actually inconsistent with the increased impediments to young people who will be trying to access GPs and benefits measures like the GP copayment? This is probably a question for the minister's representative.

Senator Nash: It is clearly a decision of the government. We believe there is benefit in the program, and it was a decision made in the context of the budget.

Senator WRIGHT: The question I am asking is: to what extent was any inconsistency considered in, on one hand, having this roll-out with a focus on youth mental health and, on the other hand, setting up a system or measure such as the GP copayment that will actually inevitably impede the ability of young people to access some mental health services? Did anyone say: 'Is this consistent? What are we doing here?'

Senator Nash: It was a budget decision.

Senator WRIGHT: Thank you for that. Is the government aware of concerns about an increased risk of suicide as a consequence of young people under 30 having to leave their family or community to relocate to find employment? That is a concern that has been raised by various stakeholders in the area of mental health.

Senator Nash: Could you repeat that? I am trying to see the link—

Senator WRIGHT: Is the government aware of concerns that have been expressed by stakeholders in the youth sector and also the mental health sector about an increased risk of suicide as a consequence of young people under 30 having to leave their family or their community to relocate to find employment under the proposed changes to Newstart for those who are under 30?

Senator Nash: I am not aware insofar as it relates to mental health issues. I will take it on notice for you.

Senator WRIGHT: Thank you for that. Is the government aware of concerns which have also been expressed about the increased risk of mental ill health among young people linked with homelessness as a consequence of young people under 30 being without income for up to six months under the proposed changes to Newstart?

Senator Nash: Again, refer to my previous answer.

Senator WRIGHT: You are not aware of anyone—

Senator Nash: I am not aware, but I am happy to take it on notice.

Senator WRIGHT: Thank you for that. In terms of the *Obsessive hope disorder* report that was released last year, during the election campaign the coalition welcomed the release of that report, which was compiled by mental health expert John Mendoza. Given this endorsement of the report at the time, I am interested in knowing to what extent the government has considered or implemented its recommendations.

Senator Nash: Again, I am not aware, but I will take that on notice.

Senator WRIGHT: Thank you. I ask the department about staffing. Has there been a reduction in the number of people employed on mental health policy within the health department over the past 12 months?

Mr Booth: On mental health policy specifically?

Senator WRIGHT: It was a bit hard to work out how to phrase this. Really, the health department is huge, but there are certainly people working on dedicated mental health programs or policies. I am interested in whether there has been a reduction.

Mr Booth: In people working on policy and programs I would need to take the exact figures on notice.

Prof. Halton: All areas of the department have been subject to reductions.

Senator WRIGHT: Perhaps you could then take on notice the reductions that have occurred in that specific area of mental health over the past 12 months.

Mr Booth: Sure.

Senator WRIGHT: Thank you. Are there any redundancies proposed, including voluntary redundancies, redeployment or alterations to positions or classifications, again in that same cohort?

Mr Booth: Again, across the department there are different programs, but I would need to take that on notice.

Prof. Halton: Let's be clear. Any reductions in parts of the department have been expressed previously. We have talked at some length about, where positions are unfunded, individuals in unfunded positions were moved to the business services centre. Certainly the implications of the budget and the existing reductions in staffing in the department, which are long-standing, have been reflected in budgets right across the department, but I think this has already been provided in evidence earlier on today. Because of the reductions we have already been going through, we are about at the size now of the allocation of staffing we have for next year.

Senator WRIGHT: Okay. What I am interested in fleshing out is if there has been a proportionate reduction in mental health as a proportion of the health department.

Prof. Halton: Mental health has received no specific attention and is subject to the generalised reductions except for where budget measures have finished. In terms of individual areas of the department, if they had an allocation for funding in respect of a specific set of budget measures which have come to a conclusion, those staff obviously disappear; but, other than that, there is no specific targeting of any particular area of the department.

Senator WRIGHT: No, and I was not really suggesting that. I guess I am more interested in whether or not there is any monitoring happening in terms of whether ultimately, perhaps even because of the vagaries of how the reduction in staffing occurs, there is potentially a disproportionate effect.

Prof. Halton: There are no vagaries in this area. It comes down to 0.whatever of a full-time equivalent. This is not vague. It is very specific. There are no accidents here.

Senator WRIGHT: I thought I understood you to say that it would depend on those who take redundancies—

Prof. Halton: No, absolutely not.

Senator WRIGHT: Alright, thank you.

In relation to NDIS—and I hear there is still difficulty in working out how this is all going to work, but this is what people want to understand—evaluation of NDIS trial sites has been done by Flinders University, and they believe that there are flaws. One issue is that the agreement includes a guarantee of service for those who are ineligible for the NDIS, but there are already case studies of people who appear to be missing out on access once they are deemed ineligible. Are you aware of any specific cases in that regard?

Prof. Halton: This is not our portfolio. We cannot make any comment.

Senator WRIGHT: I suspected you might say that. Then I do not have any more questions in this area.

CHAIR: Thank you. Senator McLucas.

Senator McLUCAS: I go to the election commitment for 10 new headspace sites. Can I confirm that that does not include any eheadspace component?

Mr Booth: Correct, there are 10 new headspace sites. The enhanced headspace sites are separate to that.

Senator McLUCAS: So there is no new eheadspace as part of this?

Mr Booth: That is correct.

Senator McLUCAS: How much will be provided for eheadspace in 2014-15?

Mr Booth: In 2013-14, $3.2 million.

Senator McLUCAS: And 2014-15?

Mr Booth: We do not have the figures for 2014-15.

Senator McLUCAS: So are you telling me the activities that were delivered under the eheadspace activities associated with the old headspace sites are not continuing?

Mr Booth: For the specific ehealth work here in terms of the services that are provided through telecom, again, as with other programs, funding has been expended to 3 June 2015 and $3.14 million.

Senator McLUCAS: So in the 2014-15 financial year it will be—

Mr Booth: We do not have that information. I am sorry.

Senator McLUCAS: Are you telling me there is not going to be any money for it?

Mr Booth: I do not have that information. I am sorry. I would need to double-check on that.

Senator McLUCAS: Can you provide that on notice?

Mr Booth: I can.

Senator McLUCAS: Thank you. Can I understand the rationale of the funding allocation over the next four years for the 10 new headspace centres? Next year is 4½, the year after is 1.4, then 1.9, then 7.2. What thinking underpins those allocations over those four years?

Mr Booth: The allocation of funding is linked with the rolling out of the headspace sites.

Senator McLUCAS: How does that happen then? There is a reasonable amount of money next financial year—

Mr Booth: There is a calculation of the amount of money that is needed to go into setting up and establishing them, and then that is rolled through for the number of headspace sites that are needed.

Senator McLUCAS: Are all 10 going to be established in 2014-15?

Mr Booth: All 10 will be rolled out and established, yes.

Senator McLUCAS: Explain to me why 2015-16 is 1.4, 2016-17 is 1.9 and then 2017-18 is 7.2.

Mr Booth: I will need to double-check on that, but essentially the funding rolls out as the headspace sites are developed.

Senator McLUCAS: The first year will establish 10, so there is a rationale that it would be expensive in that year because it is all the set-up and establishment costs, but in the last year it is 7.2.

Mr Booth: I would need to double-check on that. I will come back to you on that.

Senator McLUCAS: I imagine that will have to be on notice.

Mr Booth: Yes.

Senator McLUCAS: Can I get a fulsome understanding of what that truly means?

Mr Booth: Yes, we will come back to you on that figure.

CHAIR: I think 10 minutes of rural health might be—

Senator McLUCAS: I will put my questions about the Centre for Excellence in Youth Mental Health on notice. Thank you.

CHAIR: Thank you. At this stage we move to rural health services. Senator Moore, would you like to kick off?

Senator MOORE: Sure. Minister, I have a couple questions specifically for you. It is quite indulgent of me, because I am looking at the Senate inquiry that we did on rural health. At the time, you made very strong statements that you supported the recommendations of that Senate inquiry. I want to check with you on the recommendations we put up, of which there were 18. Has there been progress or are you pursuing progress on those in your current position?

Senator Nash: That is a very broad question.

Senator MOORE: It is a big one.

Senator Nash: I really would prefer to take that on notice and go through it in detail.

Senator MOORE: It would be really useful. I think it would be very helpful if we could get something back because of the fact that, after that report came down, in the shadow position you actually expressed very strong support for all of them. I note also the Charles Sturt University one was in there. It would be very useful to get some statements back against all of them, but I want to particularly follow up on recommendation 16, which was the existing after-hours services operating so that there should be no disruption to their administration or funding. From your perspective, what is the current government position on out-of-hours servicing?

Senator Nash: That is a very broad question. Could you narrow down for me exactly what you mean?

Senator MOORE: I am looking at the fact that one of the key issues was looking at out-of-standard-hours servicing across the board. I am looking at what the government has done around out-of-hours, particularly when we had that earlier link with Medicare locals which was looking at that issue in particular. What is the government's position on the statement on after-hours servicing?

Senator Nash: I will come back to you on that. I may need to take some advice on it.

Prof. Halton: Is your question whether out-of-hours servicing in primary care is supported? The answer is yes, it is.

Senator MOORE: Yes, but my particular question about this is to do with rural servicing. It was identified quite clearly in our inquiry that it was a particular issue in rural areas.

Prof. Halton: I can confirm that there is no lesser commitment in relation to that aspect than there is in terms of urban services. I think there is a generalised view—certainly one I share—that the out-of-hours arrangements have been suboptimal, and that applies across the board. Some places it works, but a lot of places it does not. That is certainly something that I have raised with Mr Booth and Ms MacDonald ad nauseam in relation to this. I think you can take it that we are exercised by that issue, but where it is going we cannot answer yet. I can assure you it is something which is a focus.

Senator MOORE: Under which box is it being considered?

Prof. Halton: It is under Mr Booth.

Senator MOORE: The reason I am asking it here is to do with the rural component.

Prof. Halton: It fits under primary care.

Senator MOORE: The rural aspects of that, and I would like a response on notice about exactly how, from the perspective of rural health, it is looking at it. It is actually a personal thing, as a minister with the rural health responsibility.

Senator Nash: I appreciate that and I know there was a lot of discussion at the time, particularly around the appropriateness of moving it into the previous government's Medicare local structure, so I will certainly be very happy to take it on notice for you.

Senator MOORE: I think the question we have here about red tape really fits in other areas, but the linkage between what we have seen as a proposed increase in responsibilities for individual medical practices to be involved in the issues around the co-payment. Does that constitute more red tape from your perspective—is there a red tape element to the extra responsibilities on GP services to collect and monitor the GP co-payment?

Senator Nash: From memory, one of the officials this morning—I think it was Dr Bartlett—said about 89 per cent of the practices currently already charge someone, so they have those processes in place. Certainly, the indication was—

Prof. Halton: I think it was not actually practitioners. I think he made the point that in terms of practices, our expectation is that a higher number of practices already have that infrastructure.

Senator MOORE: Is there any way we can get data that reflects the number of practices we consider rural that have that service, as opposed to other areas? My questions are specifically around the issues of rural service and the kinds of issues we raised in the Senate enquiry, and what policy is coming out of that.

Prof. Halton: Let's have a look at it, Senator. You understand as well as I do the difficulties of cutting the data in various ways.

Senator MOORE: I do.

Prof. Halton: I am happy to look at it.

Senator MOORE: And data collection—one of the key aspects of the report was looking at specific effective data collection for rural health and the elements of service. Is there anything in the program now that looks at that issue around data collection?

Senator Nash: Do you mean across-the-board data collection?

Senator MOORE: Yes, in terms of responding to how we effectively collate and collect data that responds to the information around rural health.

Senator Nash: There is certainly very much a focus on that at the moment. I am only smiling, because the department is well aware of my appetite to have good data to inform decision making. So yes, that is ongoing.

Senator WRIGHT: I am interested in what impacts the co-payment measure from the 2014 budget would have on rural communities, and what analysis there has been, if any. Particularly, I will put this in context for this committee—that is, given the primacy of GPs in mental health care and treatment in rural areas, they are often the only source of help and treatment people have access to. I am interested to know what analysis, if any, preceded that budget measure in its impact on rural mental health in Australia.

Prof. Halton: There was no specific analysis on that particular matter.

Senator WRIGHT: And I presume that the answer from the minister's representative would be, again, that it was just a budget decision?

Senator Nash: You would be correct.

Senator WRIGHT: Is there going to be any analysis as to the potential impacts? Again, because particularly uniquely in rural Australia, often it is only GPs who are available, even if people were interested in seeing other specialists, because of the distribution of psychologists and psychiatrists mainly in urban areas. Is there going to be any analysis of the effect that that will have?

Prof. Halton: Are you talking in prospective or retrospective?

Senator WRIGHT: Prospectively, I suppose, but based on data that is already available about the degree to which rural people seek mental health support from local GPs.

Prof. Halton: That is a very difficult question to answer. We all know there is much less bulk-billing in the bush than there is in the city—it is a fact. In that context there are already a significant number of people paying for services in the bush, so it is not my expectation that we will be doing any separate piece of work in relation to those issues. If the legislation passes the Senate—it is not a matter for us—undoubtedly, we will ultimate do analysis of who charges what and where.

Senator WRIGHT: Perhaps I can ask the minister's representative if this is something the government is interested in investigating? Is it perhaps an unintended consequence of a budget measure that the government would be alert to and interested in following up?

Senator Nash: I am certainly not going to speculate on what some might term as unintended consequences. We will now go through the process. Our commitment is to get the budget through the Senate. We will go through the process of implementation, but I think it is really important to remember that the reason we have taken these decisions is to ensure we have got some sustainability going forward in the health system. It is very important that we look at all these matters in the context of that.

Senator WRIGHT: But it is also very important to have sustainability of mental health treatment for people who may not have any other recourse to it, is it not? Is that sustainability not important too?

Senator Nash: I can only reiterate: there have been a number of budget measures that we believe will ensure the future sustainability of the health system. If there is anything further to that in relation to your question that might assist, I can take that on notice.

Proceedings suspended from 21:01 to 21:17

CHAIR: We will now resume with outcome 7. The plan was to run through in seriatim—to borrow Senator McLucas's phrase—except that we will do program 7.6, blood and organ donation, together with the two relevant authorities if that suits people. There are questions in almost every area, so we will have to try to stick quite rigidly to time.

Senator CAROL BROWN: How many Australians now have an e-Health record?

Mr Madden: There are about 1.66 million Australians registered for an e-Health record so far.

Prof. Halton: Ask us tomorrow morning. It will have gone up by another 3,500.

CHAIR: Why is that, Professor Halton? Does it do that every night?

Prof. Halton: Basically. Sometimes 4,000 and sometimes 3,000, but about that.

Senator CAROL BROWN: When does that 1.66 million date from?

Mr Madden: That is from 1 July 2012.

Senator CAROL BROWN: Can you remind me when the e-Health system was up and running?

Mr Madden: Registration for consumers was available through the DHS call centres from 1 July 2012, and it was available online for consumers on about 18 July 2012.

Senator CAROL BROWN: You are probably going to need to take this on notice. Could I have a month by month breakdown of the enrolments?

Mr Madden: Sure, we will take that on notice.

Senator CAROL BROWN: Are you able to provide that sort of information across the states and territories at all?

Mr Madden: Yes, we can give a break up of enrolments by states and territories, by sex and within age groups as well.

Senator CAROL BROWN: Could I get that?

Mr Madden: Yes.

Ms Powell: I was just going to let Senator Brown know that we have, in fact, provided the month-by-month breakdown of the consumer enrolments in a previous question on notice. We can update that, and I can also give you state-by-state breakdown now if you would like that.

Senator CAROL BROWN: That would be good. Given that it goes up so dramatically daily, that would be handy. That state and territory information would be particularly good to know.

Ms Powell: In New South Wales, we have 506,000; in Victoria, we have 355,000; in Queensland, we have 334,000; in South Australia, we have 169,000; in Western Australia, we have 147,000; in the ACT, we have 57,000; in the Northern Territory, we have 21,000; and in Tasmania, we have 64,000.

Senator CAROL BROWN: Would you also be able to provide me with the percentages as well?

Ms Powell: Yes.

Prof. Halton: As in of the population of the state?

Senator CAROL BROWN: Yes.

Prof. Halton: It is interesting, Senator. Given we had that discussion about the ACT and its characteristics earlier on today, I feel a small obligation to skite about the ACT. I think we are sitting on about 15 per cent of the population in the ACT.

CHAIR: What is the figure overall of the eligible percentage?

Ms Powell: Sorry, Senator. I am not quite sure I understand your question.

Prof. Halton: If it is 23 million people in the population and 1.7 rounded million, we can do the math.

CHAIR: It is about eight per cent.

Prof. Halton: That is right.

Senator MOORE: Ms Powell, when you get the data in terms of the update month by month and also the state distributions, can we now have them put into a Fierravanti-Wells table that we get at every Senate estimates?

Prof. Halton: I think she will be very flattered by that.

Senator MOORE: She knows. We have actually agreed that that is the terminology we will use.

Prof. Halton: Absolutely great.

Senator MOORE: If we can get an FW process there—and they are the kinds of data we want to keep an eye on all the way through—if we could get that every time, that would be our standard request.

Senator CAROL BROWN: Just for my interest, do you have the percentage of the Tasmanian figure there in front of you?

Ms Powell: I do not have the percentage of the Tasmanian population.

Senator CAROL BROWN: I will wait till you provide it on notice. At the last estimates we were also told that all public hospitals in Queensland had gone live with eHealth records?

Prof. Halton: With discharge summaries? I think we took that.

Senator CAROL BROWN: Can you give us a bit of an update on how that is progressing?

Ms Powell: Certainly. A total of 265 public hospitals are connected to the PCEHR. Twenty-eight of those are in New South Wales, seven are in South Australia, one is in the ACT, 219 are in Queensland, three are in Tasmania and seven are in Victoria. They are all connected to the PCEHR.

Senator CAROL BROWN: So there are 265 across the country.

Ms Powell: Some of those are connected to view information, and some of those are connected to actually upload discharge summaries.

Senator CAROL BROWN: Do you have that breakdown?

Ms Powell: I do. The only place is Queensland, where 111 are able to upload discharge summaries. The numbers are the same everywhere else. There is a program rolling out across the states.

Senator CAROL BROWN: And what is your target with connecting the hospitals?

Ms Powell: NEHTA have been working closely with all of the state governments. The way they have been doing their rollout has varied according to different things that are going on in their states. For example, in Queensland, because they had a number of upgrades happening across the state at the same time, they were able to connect all of the hospitals. In New South Wales they have started with smaller numbers and they have been progressively rolling out as they are able to.

Senator CAROL BROWN: What is your expectation of when we will be able to see all the public hospitals across the country connected?

Ms Powell: I am not sure when we will have all of them connected. In WA, for example, there is much more of a staggered approach; they will be starting in the urban areas and rolling out much more slowly into other areas. So I do not have that information. I can see what other details I can get for you.

Senator CAROL BROWN: What was the situation in Tasmania?

Ms Powell: In Tasmania three hospitals are connected.

Senator CAROL BROWN: How many specialists have registered? Do you have that information?

Ms Powell: There are 112 specialists that we know have registered to connect to the system. The way the registration works is that health provider organisations register to use the system as well. For example, if you have a hospital that is registered to use the system, specialists within that hospital might be accessing it. So we do not have those numbers.

Senator McLUCAS: Do you have the number of private specialists who are registered?

Ms Powell: I do not have that information.

Mr Madden: The way we keep the tally of who is registered is that, if you are registered, as Ms Powell put it, as a provider organisation, all of the specialists, GPs and health providers within that organisation can use it. We

cannot keep a count of how many are in that. For those who have registered with a health provider identifier as an individual, we can know the specialty or the particular type of healthcare provider they are, but it does not discern whether they are a private practice or a public practice. We do know what type of provider they are, but not all providers register with a healthcare provider identifier as an individual. Most come through as an organisation.

Senator McLUCAS: If you were a specialist who did a little bit of work at a public hospital as a VMO, you are captured there and you do not have to reregister in your private practice?

Mr Madden: That is right. They could be registered in their own right within their own private practice but, if they are in a hospital as a public VMO, they will be using hospital system's HPI-O to get that.

Senator CAROL BROWN: I want to move to the review. I know it has been released, but when was the review completed?

Mr Madden: The review was tabled around 23 December 2013. It was released publicly on 19 May 2014.

Senator CAROL BROWN: Did you say 24 May?

Mr Madden: 19 May.

Senator CAROL BROWN: When will the government be formally responding to the review?

Senator Nash: My understanding is we are working through that at the moment, Senator. We are working through the response to the review now.

Senator CAROL BROWN: No suggestion of a time frame there, Minister?

Senator Nash: I can take it on notice for you—but, at this stage, not from me.

Senator CAROL BROWN: Not in the near future?

Senator Nash: I would not like to make an assumption.

Prof. Halton: Let us be clear: at one level the government already has responded to the review by funding actually the PCEHR—

Senator CAROL BROWN: Funding for the one year.

Prof. Halton: Yes, absolutely. And the minister is on the record in relation to the forward commitment to this.

Senator CAROL BROWN: I have seen what is in the budget papers and the funding provided for 2014-15. It is what is beyond that, obviously, that is of interest.

Prof. Halton: Yes. But, again, go to the language used by the minister. There are some issues that need to be resolved which, as the minister says, are being worked on at the moment. The PCEHR or what it becomes based on the recommendations of the review, with all the things that are covered in the review, is an important part of infrastructure.

Senator CAROL BROWN: Are you able to tell me what the cost of the review was?

Mr Madden: I do not have the cost with me. Ms Powell, do you have that detail with you? I am pretty sure we provided some of that in the last series of estimates, so it will not be hard to pull out.

Ms Powell: Yes, I do have that information. The total cost of the review, all up, was $196,000.

Senator CAROL BROWN: Has the department provided a brief to the minister on the review?

Prof. Halton: Several.

Senator CAROL BROWN: Right. I will not ask when, then. The transition from the personally controlled electronic health record system to the 'my health' record—has an appropriation been made for that transition?

Mr Madden: At the moment that is one of the recommendations in the review and we do not have a formal position on any of the recommendations.

Senator CAROL BROWN: So that is under consideration by the minister—whether he will take up that recommendation.

Senator Nash: That is right.

Senator CAROL BROWN: How many staff are employed on the implementation of the eHealth records?

Mr Madden: On the current operation of the system?

Senator CAROL BROWN: Yes.

Ms Powell: In terms of the staffing arrangements, the information I can give you that is probably the most useful is the number of staff that are working in the division, which covers a whole range of activities: the

operation of the eHealth record, policy, work on the legislation and many eHealth related activities. We have got 57 staff at the moment, plus a number of contractors.

Senator CAROL BROWN: Can you tell me how many contractors?

Ms Powell: We have 18 contractors in a variety of arrangements.

Senator CAROL BROWN: Doing a variety of roles within the division?

Ms Powell: That is right.

Senator CAROL BROWN: I will not ask the government's position on some of the other recommendations. I am assuming that is all under consideration. The e-health summit and implementation of the clinical trial functionality into jurisdictional e-health systems—are we proceeding with that?

Ms Powell: The e-health summit?

Senator CAROL BROWN: Yes.

Ms Powell: I am thinking that you might be referring to a conference run by CHIK Services earlier this year. I am not sure what the e-health summit is.

Prof. Halton: It is not self-evident what that means, Senator.

Senator CAROL BROWN: What is that?

Prof. Halton: It is not self-evident what you mean by eHealth summit.

Senator CAROL BROWN: It is my understanding that there was a summit that proposed—

Prof. Halton: By whom?

Senator CAROL BROWN: I understand that it was a decision made between the state and territories and the Australian government. I could be wrong, but that was proposed.

Prof. Halton: Not that I have any visibility of.

Senator CAROL BROWN: Just before I finish, the National E-Health Transition Authority—what is the appropriation for that? I cannot find it here.

Mr Madden: The Commonwealth's share of that is $34 million and that means that the state contribution combined would be the same value.

CHAIR: Has the state contribution been made, Mr Madden?

Mr Madden: As far as I am aware, all but three states have worked through that to commit. The other three are still working through the administrative processes.

CHAIR: Are you able to tell us which—

Mr Madden: I will take that on notice, if that is all right, Senator.

Senator CAROL BROWN: So that $34 million is over how many years?

Mr Madden: For one year. That covers the operation and servicing of things like the Healthcare Identifiers Service and the National Authentication Service for Health, as well as all the standards.

Senator CAROL BROWN: Okay. I am just trying to find some information about the summit. I might have to come back and ask for some indulgence, Chair. While you are there and I am looking through my information, is there an ongoing promotional strategy for e-health records?

Mr Madden: No, Senator. We continue to provide help, support and information to people who make inquiries or are wishing to connect to the system. There is a level of information and communication out there in the community and through the public hospitals through the admission process so people are made aware of the fact that they can have an e-health record, but we do not have any publicly espoused communication strategy from the Commonwealth at the moment.

Senator CAROL BROWN: Is it just through those two streams that you just mention?

Mr Madden: All of the information which has been provided publicly about the e-health system is still out there in private and primary practice. It is available through the hospitals and clinics. It is all there. It is all of the information that we put out last year. We have not embarked on a campaign or any advertising or education beyond what we have already done so far.

Senator CAROL BROWN: You are not considering anything like that?

Mr Madden: While we are considering the position on all of the recommendations, how far we push those things will depend on how we go with some of those recommendations.

[21:38]

CHAIR: As there are no other questions in this area, we will move on to program 7.2, Health information. Are there any questions there? No? I think we can safely assume that we do not have questions there. Program 7.3, International policy engagement. No? Program 7.4, Research capacity and quality.

Senator McLUCAS: Where does health and hospital funding evaluation sit?

Prof. Halton: Infrastructure.

CHAIR: Health infrastructure, okay. If we go to program 7.5, as far as I am aware we have Senator Brown with questions on regional cancer centres, and you have some questions now, Senator McLucas; is that right?

Senator McLUCAS: Professor Halton, when you said 'infrastructure'—

CHAIR: Health infrastructure, program 7.5—

Senator McLUCAS: Okay.

CHAIR: That is where we are now. Senator Brown, do you want to ask your questions on regional cancer centres and get those done and dusted?

Senator CAROL BROWN: I will just start by asking for an update on how the centres are progressing. We have had a list kindly provided to us. There are the 26 all up?

Ms Anderson: Yes. As you were seeking the list: we have 14 centres completed and another 12 which are under construction. There is some ambiguity around two of those centres. As you would see in the far right-hand corner of the list, it indicates an expected date of completion. There is one there which is listed for May. I have not been able to ascertain whether that has in fact been completed. I would be happy to provide advice to you quickly on that.

Senator CAROL BROWN: Fine, yes.

Senator MOORE: That is the ACT one?

Ms Flanagan: Yes, that is correct.

Senator MOORE: How far away is it, Ms Anderson?

Ms Anderson: I am sorry; I do not have that information, but I am happy to provide it.

Senator MOORE: That is probably the one that will be easiest to check out.

Ms Anderson: Yes, indeed. You could probably go and look.

Ms Flanagan: Actually, my recollection on this was that they had a water main burst or something like that, which has—

Senator MOORE: Deferred.

Ms Flanagan: yes—caused a few issues. I will double-check, but that is my understanding—that it did affect the regional cancer centre.

Senator CAROL BROWN: If we proceed to No. 9 on the list—

Ms Anderson: Yes.

Senator CAROL BROWN: is that all on target for that completion date listed?

Ms Anderson: As far as I am aware.

Senator CAROL BROWN: The Townsville one?

Ms Anderson: Similarly.

Senator CAROL BROWN: I can go through them all. The Springfield cancer centre is all on target?

Ms Anderson: As far as I am aware. I would be happy to take on notice a request to advise if any are moving off target, but as far as I have been—

Senator CAROL BROWN: How often do you get reports about whether they are proceeding appropriately?

Ms Anderson: Typically, we are informed at the point at which a milestone payment is due or, depending on the terms of the project agreement, six-monthly or annually.

Senator CAROL BROWN: And the Tasmanian one?

Ms Anderson: Yes, as far as we are aware.

Senator MOORE: Ms Anderson, can you give us any detail on the Townsville-Mount Isa integrated service? There are three in the list that have that 'integrated service' beside the name. What does that mean? You have a

cancer centre—and luckily I have visited quite a few of these—but what is the difference between a centre and one that is, like the Townsville-Mount Isa one, an 'integrated' regional one?

Ms Anderson: Beyond the obvious difference of the name, I would have to take that on notice to provide an accurate response to you.

Senator MOORE: I would like to have the difference as to what constitutes integration in that sense. Down there is one at Bundaberg, which is 'Bundaberg integrated service'. Bundaberg is not the same geographic set-up as Townsville-Mount Isa. I thought originally it was something that had to do with the regional locations, but it cannot be. I would just like to get some information—I could not find it on the website—about what 'integrated' means.

Ms Anderson: I am happy to provide that.

Senator MOORE: That would be great.

Senator CAROL BROWN: For the centres that are up and running, do you receive reports about the services? Do you get any reports back?

Ms Anderson: We did cover this in the last Senate estimates. It is a capital infrastructure program. Beyond the provision of capital and the acquittal of the expenditure of that capital, we do not inquire closely or follow closely the operation of the actual service. The funds are acquitted with completion and construction, and then we expect the state or territory or indeed the non-government provider, the operator, to run the facility as planned.

Senator CAROL BROWN: I think that is all from me.

Senator McLUCAS: On the rural and regional general practice teaching infrastructure grants, what was the justification for the government's decision that those grants will cease?

Mr Booth: The rural and regional teaching infrastructure grants, the new budget measure? Or are you referring to the previous—

Senator MOORE: The rural and remote, the one that is ceasing.

Mr Booth: The NRRHIP.

Senator MOORE: Yes.

Senator McLUCAS: NRRHIP, yes.

Mr Booth: The NRRHIP was an annual grants round, as you are aware. There were six rounds done, but the last round was in 2011. There has not been a round done for the last three years.

Senator McLUCAS: The funding reduced by $22.3 million. It was originally meant to be over the next four years, I understand?

Mr Booth: No decision was made by government to actually do another round after round 6, so there was never—

Prof. Halton: And that was in 2011.

Mr Booth: And that was in 2011, so I do not know what has happened since then. There were six rounds done, and that was completed.

Senator MOORE: So there was $22.3 million sitting there in a budget line, not touched?

Mr Booth: That is correct, as far as I know.

Senator McLUCAS: What was the quantum that a rural general practice could receive under the NRRHIP?

Mr Booth: Under the NRRHIP?

Senator McLUCAS: Yes.

Mr Booth: I think I probably have the exact figures. It was a small grants program specifically aimed at improving infrastructure. From memory, it was between $150,000 and $300,000 for the grants that were provided under that program.

Prof. Halton: Depending on the nature of the project.

Senator McLUCAS: And it has been replaced now with the rural and regional general practice teaching infrastructure grants?

Mr Booth: That is the new program.

CHAIR: Will that funding transfer over?

Mr Booth: There is funding of $56.5 million, I think, through—

CHAIR: Including the $22 million that has been sitting around doing nothing for three years?

Mr Booth: I do not know. I do not know the budget arrangements there. I will just double-check on that one and give you the exact amount. Yes, $52.5 million was the budget announcement for that program.

Senator McLUCAS: What will the grant eligibility criteria for the new program be?

Mr Booth: For this particular one?

Senator McLUCAS: The new one, yes.

Mr Booth: For the new one, the grants are aimed at improving teaching facilities in GP practices, so it will be targeted at general practice. The eligibility will be determined by location in rural and regional areas, so RAs 2 to 5, and it also has an element of it with an equal commitment from the practice concerned.

Senator McLUCAS: Did the previous program have that requirement?

Mr Booth: The previous NRRHIP did not, no.

Senator McLUCAS: That is the point of difference.

Mr Booth: The NRRHI Program was just a grant.

Senator McLUCAS: Has any assessment been done of the capacity of regional and rural practice to do that dollar-for-dollar co-investment?

Mr Booth: I do not know. It was a government election commitment. I do not know.

Senator McLUCAS: When will the program begin?

Mr Booth: We are looking at doing the policy work at the moment in developing guidelines. The anticipation is that the first grants round would be taking place this year.

Senator McLUCAS: Was the previous program also Australian Standard Geographical Classification Remoteness Areas 2 to 5?

Mr Booth: It was 2 to 5 as well, yes.

Senator McLUCAS: So you are designing the eligibility guidelines at the moment. Will there be an allocation in the 2014-15 year?

Mr Booth: The $52.5 million goes over three years. It goes over three years because, as you know, infrastructure programs take a bit of time to actually get going and do the assessment and those kinds of things. So the program will run over three years.

Senator McLUCAS: Is there going to be an annual grant round?

Mr Booth: No, it is a single—

Senator McLUCAS: A single application process?

Mr Booth: Yes, but it will be done, and the work is being done at the moment in terms of how many can be done in any one particular year and exactly how the guidelines and the process will work.

Senator MOORE: Is that the same way that the other program worked?

Mr Booth: Yes, that is right. They tended to be done in rounds for NRRHIP. There would be an annual round, but it could take over one year to actually do the building.

Senator MOORE: They knocked down walls and they changed their access ways so that wheelchairs and things could fit in.

Mr Booth: For the NRRHI Program, yes. It was specifically designed to improve infrastructure, whereas this one is targeted on training.

Senator MOORE: Training rooms, yes.

Senator McLUCAS: Is it just training rooms?

Mr Booth: It is training facilities. The wording is 'for teaching and training'.

Senator McLUCAS: So not consultation rooms?

Mr Booth: No, it is for teaching and training.

Senator McLUCAS: Will that funding be tied to the placement of students in a regional and remote practice? Would the practice have to say, 'We do this number of training sessions a year'?

Mr Booth: I do not know if it will be tied to specific numbers, but for teaching and training there needs to be some teaching and training being done.

Senator McLUCAS: What measures does the department have in place to ensure that there is compliance with actually taking on students in those GP practices that have received the grant under the National Rural and Remote Health Infrastructure Program?

Mr Booth: For this program, the rural and regional teaching infrastructure grants—

Senator McLUCAS: Sorry, yes.

Mr Booth: we are going through the guidelines at the moment, but, as with other infrastructure programs that we run, there will be milestones tied to particular areas, and there will be reporting and monitoring of the use that Commonwealth funds have been put to.

Senator McLUCAS: Thank you very much.

CHAIR: The Health and Hospitals Fund evaluation is in program 7.5.

Senator CAROL BROWN: Can I just say, though, that I found the summit and it was supposed to be funded under the Diagnostic Imaging Quality Program.

CHAIR: An e-health summit?

Senator CAROL BROWN: Yes. Anyway, I should have asked about it under 3.3.

Prof. Halton: There you go.

Senator CAROL BROWN: Just to let you know: the grant funding was removed.

Ms Flanagan: What page is that on in the measures? It is in the measures description?

Senator CAROL BROWN: No, it is not. What I just read out was not in the budget other than the amount of money that was saved by closing or ceasing the Diagnostic Imaging Quality Program. But, under that, there was grant funding for the summit.

Prof. Halton: There you go.

Senator CAROL BROWN: You could let me know on notice if I am wrong.

CHAIR: That one had better go on notice, Senator Brown.

Senator MOORE: Can we get an update on the review of the Health and Hospitals Fund, Ms Anderson?

Ms Anderson: We have embarked on a two-stage process for this evaluation. We firstly commissioned the development of an evaluation framework, and that work was completed in July 2013. We then went out to the market. We issued a request for quotation, and PricewaterhouseCoopers has been successful in securing the consultancy to undertake the evaluation. That work is due for completion at the end of this month, June 2014. The evaluation has two components to it. Firstly, it will look at the achievements and challenges or barriers of the Health and Hospitals Fund program strategic capital investment, and the second component is to look at the investment in medical research infrastructure projects specifically and to ascertain the benefits to the community and also the degree to which the research outcomes have been transferred into practice.

Senator MOORE: So the next steps in the review and the time frame would be getting the report finalised by the end of this month?

Ms Anderson: Yes.

Senator MOORE: Does it then go to government?

Ms Anderson: Yes.

Senator MOORE: And it would then be up to government to determine what, if anything, is made public and the time frame for that?

Ms Anderson: That is correct, yes.

Senator MOORE: How much in total funding has been committed to projects through the HHF?

Ms Anderson: To date, all up, funding of $4.94 billion has been committed to 220 projects.

Senator MOORE: Do they include regional targeted rounds?

Ms Anderson: Yes, that is correct.

Senator MOORE: Are there any funds remaining in the HHF bucket?

Ms Anderson: As we talked about in the opening today, there is a balance of some $900 million.

Senator MOORE: That is the $900 million you were talking about?

Ms Anderson: That is uncommitted funds, largely the result of earnings on interest in the fund itself rather than a lack of expenditure. As I just said, we have spent $4.94 billion from the fund on those 220 projects. But,

over the course of the period the fund has existed, naturally its balance has accrued interest. That $900 million is the accrued interest.

Senator MOORE: Is there expected to be a next round of funding through the HHF process?

Ms Anderson: With the establishment of the Medical Research Future Fund, it is expected that the uncommitted balance of the HHF fund will roll in and become the preliminary investment in that fund, subject to the passage of the legislation.

Senator MOORE: That means that the remaining funds from the HHF are proposed to be transferred to the New Medical Research Fund.

Ms Anderson: That is right.

Senator MOORE: Do we know how that is going to happen? Do we know what the process will be for how the transfer will take place?

Ms Anderson: As I understand it, the act establishing the HHF will be repealed and new legislation will be used to establish the MRFF.

Senator MOORE: So there will have to be two separate pieces of legislation—one to close down HHF and another to establish the Medical Research Future Fund, and underneath that legislation would be the details of the process . Minister, is that how you see it operating?

Senator Nash: That would be my expectation . If that is incorrect, I will come back to you.

Senator MOORE: Is the government's timing schedule for that available?

Senator Nash: No.

Ms Anderson: The plan is to start up the new fund on 1 January 2015 . But, again, it is subject to the passage of the legislation through both houses.

Senator MOORE: The previous government had announced a number of projects which were to be funded by the Health and Hospitals Fund, including the Westmead Hospital redevelopment, funding for the Westmead Millennium Institute for Medical Research and upgrades in equipment at St George Hospital, Nepean Hospital, Flinders Medical Centre and others. Is it your understanding that these projects will be proceeding?

Ms Anderson: Without going into the detail of each of those projects individually, the government has indicated very clearly that it will progress all of those projects it has announced or to which it has confirmed a commitment. As I understand it, all of those projects you identified will be included , but I will take that on notice to make sure.

Senator MOORE: The one I am particularly interested in is the Hummingbird House project in Queensland. That entails a grant from the state government as well.

Prof. Halton: Probably the way to think about this is that there has been no decision taken by government to defund any of the existing commitments. We cannot say with confidence that one of them will not have issues, but they will not be of our making. In terms of managing them, it is our expectation that (1) the money will be available, which it is, and (2) that they are proceeding.

Senator MOORE: Find me where the money would be, Professor Halton. The fund has now listed all the things it has funded. I will not know until we get the answer back whether the ones I have named have had that money allocated or not. My understanding from listening to answers this morning is that one fund is going to be closed down. There is that $900 million left in it which is not core money; it is interest.

Ms Anderson: All of those projects which are subject to commitments by governments, even those which are not yet contracted, will be funded from the HHF.

Senator MOORE: From the $4.94 billion?

Ms Anderson: Yes. The funds which are set against commitments will be preserved and remain available across the forward estimates to fund that infrastructure. The residual amount—that which is not committed—is the small parcel of funds which will be put as the first investment into the Medical Research Future Fund.

Senator MOORE: So the trick would be to be one of the ones that has committed funding—and the expectation is that that funding will be maintained and then anything left over will go across?

Prof. Halton: That is it.

Ms Flanagan: It might sound very attractive just sitting there, but in fact it is not.

Senator MOORE: It is not that attractive? It is certainly attractive.

Ms Flanagan: It is attractive, but very difficult to access. For any interest that is being earned on the fund, if it is actually drawn down in an accounting sense, an equivalent amount of savings needs to be found from within the health portfolio.

Senator MOORE: Because it is interest, not core funding?

Ms Flanagan: because it is interest.

Prof. Halton: No, it is actually to do with the structure of the Commonwealth public account. The bottom line is that it is sitting on the Commonwealth account. I think we have discussed this in the past.

Senator MOORE: Yes. And the expectation is that it will not sit on the HHF Commonwealth account, it will go to the Commonwealth account of the medical research fund?

Prof. Halton: That is right.

Senator MOORE: So we cannot think of this being a bucket of $900 million just waiting there to be consumed.

Prof. Halton: That is right. But there is a ring fence around the components of money which are committed to projects.

Senator MOORE: We will put all those questions on notice so we can get confirmation on that. If the HHF is closed, how will infrastructure redevelopment and equipment upgrade projects be funded? If HHF is closed, what will be the current budget arrangements to fund things like infrastructure redevelopment and equipment upgrades?

Prof. Halton: We actually go back to the previous arrangement. It is important to remind ourselves that this is a fairly unusual intervention by the Commonwealth in capital funding. As you know, a number of programs do come with capital; we have just been discussing some of them, including some that did not have the most successful trajectory. But it has not been a feature of funding over the many years that the Commonwealth makes significant investments. This was an opportunity that presents itself.

Senator MOORE: It has always been a discussion point, yes.

Prof. Halton: Yes. And, let's be honest, we were very happy to spend in a way that advantaged the health system—as you would be. But basically we will revert to situation normal.

Senator MOORE: We talked this morning about the fact that we do not know the detail of what is going to be in the medical research fund. Was the issue of infrastructure discussed in the medical research funding?

Prof. Halton: Specifically, not that I am aware of.

CHAIR: We are now going to program 7.6, 'Blood and Organ Donation'.

Australian Organ and Tissue Donation and Transplantation Authority

National Blood Authority

[22:03]

Senator McLUCAS: Ms Cass, could you update the committee on the latest rates of organ and tissue donation?

Ms Cass: There are a couple of significant achievements to note. I will start with the Paired Kidney Exchange Program and then go to progress to date more generally. The Paired Kidney Exchange Program, as some of you may know, was established in October 2010. It is a unique national program that provides for incompatible living kidney donors and recipients to be matched with other incompatible pairs to allow living kidney transplantation to occur. These are recipients who are very highly sensitised. They have a very high antibody profile and have minimal chance—less than one in 100—of actually receiving a kidney through our normal deceased-donation program.

So far under this program 93 people have actually received a kidney transplant and a further three are scheduled. On 22 May—so, in the last couple of weeks—in a national first, there was a six-pair domino series of kidney transplants undertaken in which 12 people basically exchanged kidneys between pairs in an exchange chain. That involved more than 80 surgeons and clinicians in three hospitals in Melbourne to achieve that incredibly complex set of carefully timed procedures. We have just undertaken another match run of these incompatible pairs and another 13 have been successfully matched—

Senator McLUCAS: Thirteen pairs?

Ms Cass: 13 pairs—across four states.

Senator McLUCAS: That was the question I was going to ask about the first domino event: they weren't all Victorians?

Ms Cass: They were all Victorian; that was all undertaken in Victoria. The Paired Kidney Exchange Program has done chains before of less than six pairs, and they have been done across state boundaries previously by having 12 people all in theatre, basically at the same time. That was run in one state to make sure that it worked logistically. We have just done another run with 13 pairs matched currently across four states. Obviously, there will be work to see how, logistically, that can be managed.

That is an example of a very successful program which basically allows access to transplantation for people who otherwise really would not get it. It is achieved through leadership from the Organ and Tissue Authority but principally through the marvellous clinical staff in Perth and Professor Paolo Ferrari, who manages this national matching process and the program with all of the transplant units across Australia.

The second thing that I will mention is progress to date. You know that generally the aim of this program is to achieve a sustained increase in organ and tissue donation for transplantation. There have been four years of significant growth since 2009, with 391 deceased organ donors last year that ultimately allowed 1,122 Australians to receive access to a transplant. It has so far been equivalent to a growth of 60 per cent in the number of donors in Australia, from 247 in 2009, when this all first started, to 391 last year. This has also translated into an almost 40 per cent growth in the number of recipients, from 808 in 2009 to 1,122 last year. When that is turned into a population rate, that equates to a growth from 11.4 donors per million population to 16.9.

We have set a target of 25 donors per million population by 2018 and a series of KPIs, key performance indicators, to reach that target, the end point. Those KPIs are basically that we should, through the DonateLife Network staff, be able to achieve a 100 per cent request rate from potential donors, a 75 per cent consent rate and a 70 per cent conversion rate. So far we have seen a significant growth in those three indicators. Between 2010 and last year, our request rate has increased from 92 per cent to 96 per cent; the he consent rate has grown from 54 per cent to 62 per cent; and the conversion rate, which is the number of actual donors over the potential pool, has increased from 44 per cent to 53 per cent. That gives you an indication of the change over the last four years. It is a significant amount of work across the DonateLife Network, but there is more to be done. There is capacity for Australia to receive greater rates and we are working with the states and territories and the public hospital system to make sure that is achieved.

To the end of May this year, the provisional outcome that we have achieved is 165 deceased donors. That is equivalent to a monthly average of 33 donors so far this year, which is much higher than the 20.6 per month when we first started in 2009 and is higher than the monthly average of 32.6 that we achieved in 2013. We are on track, though it is very hard to predict at the five-month point, to achieve a higher number of donors than last year. We are not currently at the monthly average of 36 donors, which we would like to achieve this year, so there is more work that we need to continue to do. As you know, we are in the fifth year of a 10-year reform program with very clear targets and reform strategies that have been set out with states and territories and the public hospitals, and we will continue to work to achieve them.

Senator McLUCAS: You are working closely with the states and territories, but are those targets agreed with all states and territories?

Ms Cass: They are agreed with states and territories, yes.

Senator McLUCAS: The budget shows that the Organ and Tissue Donation and Transplantation Authority and National Blood Authority are about to married. Minister, what was the rationale behind the amalgamation of these two, can I say, very different entities? They do very different things, they deal with bits of body, but that is the only thing that is frankly similar.

Senator Nash: They are indeed different. I do think there is some synergy there. The rationale was to get some efficiencies through putting the two together, it made sense in terms of streamlining how we do those things in both of those agencies to bring them into one.

Senator McLUCAS: What are the savings that will be made by amalgamating the two entities?

Senator Nash: I will take some advice on this. I am not sure there was actual saving with the amalgamation, it was very much a streamlining of operations, bringing the two together. I stand to be corrected, but that is my recollection that there was not an actual saving.

Senator McLUCAS: So there are no savings?

Ms Flanagan: Senator, I think there is predicted to be a small saving. This is part of a rationalisation, I think, as we discussed earlier today, across government of a range of agencies. There is a small saving with the merger of the two organisations.

CHAIR: Is that primarily in back office?

Ms Flanagan: It is certainly the intention with all of these mergers, or marriages, or amalgamations, that the core functions are not impacted. It is making efficiencies in back office or support functions. That is the intention.

Senator McLUCAS: What is the quantum that is proposed to be saved by the amalgamation of two very different authorities?

Ms Anderson: It would be fair to say that a request has been received for a costing of the merger and that work is now underway. I do not believe that there is a firm position on the expected target.

Senator McLUCAS: So the government made this decision without any knowledge about whether or not it would deliver any savings at all?

Ms Anderson: No, that is not the case. As Ms Flanagan said, there is an expectation that for corporate services there would be benefits in bringing the two organisations together and some cost savings through back-of-house function, amalgamations, payroll, IT services and so on. Ms Flanagan also said, the government is very committed to ensuring the continuity of the work of each of those agencies, which they consider to be vital. There is an expectation that bringing the two agencies together will achieve some savings. The quantum of savings to be achieved is something we still need to work through.

CHAIR: Are you able to make this your last question, Senator McLucas—

Senator McLUCAS: No.

CHAIR: because there are other people wanting to ask questions in this area.

Senator McLUCAS: So it is just back-office savings that are proposed? Are there any proposals to change the staffing profile of either authority?

Ms Anderson: By definition, these organisations tend to have most of their expenditure on staff. So a back-of-house consolidation may yield some savings from a reduction in the required number of staff to run the corporate services.

Senator McLUCAS: Ms Cass, what is your staff profile?

Ms Cass: We have a headcount of 28 and an FTE of about 26, I think. I will just give you the exact figures—yes: headcount, 28; FTE, 26.2.

Senator McLUCAS: And Mr McJames?

Mr McJames: Our figures are that we have, as of 28 May, 40 ongoing staff and 10 non-ongoing.

Senator McLUCAS: That is FTE?

Mr McJames: Total FTE of 50.

Senator McLUCAS: Okay. And what proportion—

CHAIR: This will have to be your last question, Senator McLucas.

Senator McLUCAS: This is a huge change to a program that has been extraordinarily successful—

CHAIR: Well, perhaps you should have started earlier on with questions, then. Last question.

Senator McLUCAS: What proportion, Ms Cass, of your staff could you describe as back-office staff? I think that was the term that was used.

Ms Cass: A small number. I actually do not have that with me. I would have to provide that on notice.

Senator McLUCAS: Could you also provide to us a list of the types of activities that your staff undertake? You have the coordinators in each state. You have the people who do this marvellous work that has facilitated the saving of at least 100 people already in the paired kidney activity. It has also saved costs to the Commonwealth of dialysis and productivity. Mr McJames, can you tell me how many of your staff would be described as back-office staff?

Mr McJames: If I could take that on notice. It would be relatively small. The figure that rings a bell is approximately eight, out of 50.

Senator McLUCAS: Eight out of the 50. Is there any proposal, Minister, to change the leadership of either of these organisations?

Senator Nash: I am not aware that that is being considered. Certainly, if that is not correct, I will come back to you. But I think it is important to make the point that it is about better aligning the administration arrangements and reducing duplication and red tape. The government have been very clear that that is an across-government priority for us, and I think this is a sensible amalgamation that will not impact on the outcomes that we expect from either of the existing agencies.

Senator McLUCAS: I do not accept your evidence, Minister, that there are synergies here. These are two quite separate organisations. I want to place on the record to both the Organ and Tissue Donation and Transplantation Authority and the National Blood Authority Labor senators' thanks for the work that you have done in your current construction. I really hope there is no change, particularly in terms of the rates of organ and tissue donation and the great success that we have achieved—that your organisation, Ms Cass, has achieved. If that upward trajectory changes in any way, I will be looking to you, Minister, because if that changes it means that there has been a change in effort, in what these wonderful staff have been able to do—to deliver such marvellous outcomes. Mr McJames, I want you to pass on to your staff too the thanks of Labor senators for the work that your officers have done over many years to ensure, in particular, that the blood supply 'wastage' issue has been dealt with. I do thank you.

Senator Nash: Senator, if I could just respond very briefly. I do not disagree at all. I have been working very closely with both agencies. I concur with the comments that you have made about the outstanding job that they are doing. The issue of organ and tissue donation is very much a bipartisan issue, I believe. Certainly, this government will be doing everything we can to ensure that we do increase the rates of donation to lead to better outcomes for both of the agencies themselves and also the people we are trying to assist.

CHAIR: Ms Cass, on notice, would you be able to tell me if there are any people with cognitive impairment on your transplantation waiting lists?

Ms Cass: I will look into that.

CHAIR: Thank you. As far as I am aware, no-one had questions for 7.7, regulatory policy.

Therapeutic Goods Administration

[22:20]

CHAIR: Senator Xenophon and Senator McLucas want to ask questions. Senator Xenophon, would you like to kick off?

Senator XENOPHON: I would be delighted to. Are you aware of the *Four Corners* program aired last Monday in relation to DePuy hip joint replacements?

Prof. Skerritt: I am.

Senator XENOPHON: The program found that DePuy had received accelerated approval from the FDA in the US because the ASR device was 'substantially equivalent to other approved devices'. Was the device's Australian approval based in part on the FDA's approval and approval methodology?

Prof. Skerritt: No, it was not. We work in a device regulatory framework that is aligned with the European system rather than the FDA system.

Senator XENOPHON: But the TGA bases many of its approvals on whether a device has been approved in other jurisdictions. Is that correct?

Prof. Skerritt: Yes, but it is Europe rather than the United States, Senator.

Senator XENOPHON: What is the TGA's response to allegations raised in the *Four Corners* report that DePuy only provided a limited amount of testing data, only testing one size of the device when there were 12 available to the FDA? Does that sort of thing happen here in Australia?

Prof. Skerritt: In response to the issue with metal-on-metal joints, as you are aware, we reclassify joints from class IIb to class III. With the reclassification to class III we are able to call in a greater amount of evidence. We did certainly have information from the conformity assessment of those joints. It was similar to the type and amount of information that we had for conformity assessment of other joints, including the competitive products that were named in that program.

Senator XENOPHON: There were 12 sizes of the device available; were all of those tested here in Australia?

Prof. Skerritt: We do not test the different devices individually before market authorisation.

Senator XENOPHON: But did you rely on the testing in Europe, for instance, to make your decision in respect of the approval of the device?

Prof. Skerritt: We assessed the information that was provided to us based on testing and performance in Europe, as is our usual framework for assessment of devices.

Senator XENOPHON: I understand that. Did Europe test all of the 12 devices or did it only test one or two?

Prof. Skerritt: I would have to take that question on notice.

Senator XENOPHON: It is a pretty fundamental question, isn't it?

Prof. Skerritt: It is important from what we know now in the context of devices, especially given that larger acetabular joints and femoral stems can appear to be causing more problems with metal-on-metal joints.

Senator XENOPHON: In the limited time available, can you take on notice how the TGA ensures that devices approved in other jurisdictions have gone through the appropriate processes and testing?

Prof. Skerritt: We will take that on notice.

Senator XENOPHON: Footage from the court case in the US shown on *Four Corners* shows that DePuy admits that the testing it undertook did not reflect any of the problems that occurred with the devices. What implications does this have for the level and type of testing required by the TGA and also for the credibility of DePuy and any associated companies in terms of any further approvals they may be seeking for other devices?

Prof. Skerritt: To answer your second question first, we are a product regulator, so we look at the performance of the product based on the information we are provided and any other questions we may ask about the product. The corporate performance and behaviour of the companies is a matter for others, whether it is ASIC or ACCC.

To go to your first question, we are always looking at clinical evidence and other standards for devices. Over the next six months, we have already let a contract with groups of clinicians to help develop more systematic and detailed critical evidence to provide sponsors with an example of what TGA will be looking at more clearly. To date there have not been detailed clinical evidence documents for different classes of medical devices.

Senator XENOPHON: My final question is this: in Australia problems with the device were raised by the NJRR as early as 2007, and I still have to see constituents with horrible, shocking problems from these devices. As raised in the committee inquiry, does the TGA acknowledge that if they had acted on the NJRR's advice and withdrawn the device, many people would have been spared the pain and sickness and disability they now suffer?

Prof. Skerritt: I would like to make the point that the withdrawal of these devices from the Australian market was actually well ahead of a worldwide recall. We withdrew them in 2009—

Senator XENOPHON: But you had the information back in 2007, didn't you?

Prof. Skerritt: I would have to take that on notice. It was in the 20007 annual report. We look at that annual report. We then consult with groups of commissions. We, for example, have what used to be known as the orthopaedic experts working group review that data and, over the course of 2008, a group such as that did. Yes, it was from their 2007 annual report, which would have been provided to us in 2008. We then, through OEWG, the Orthopaedic Expert Working Group, look at such data and then the hip was removed from the Australian market in 2009, which was well ahead of its removal in other markets.

Senator XENOPHON: Finally, a supplementary: can you confirm that the TGA still would not have considered this advice of the National Joint Replacement Register by the time DePuy in effect voluntarily withdrew the device from 2009.

Prof. Skerritt: I will take that chronology on notice, thank you.

CHAIR: That is your final, final question.

Senator XENOPHON: That is my final, final, final question.

Senator McLUCAS: I want to go to the use of oxycodone or oxycontin, which is often referred to as 'hillbilly heroin', I understand.

Prof. Halton: According to the newspapers, Senator.

Senator McLUCAS: According to the newspaper. There is a new drug on the market which improves safety by ensuring that the drug cannot be easily tampered with that is crushed and taken in an inappropriate way. What are all the forms of oxycodone currently listed on the ARTG?

Prof. Halton: Can we go to the premise of the question first? We are happy to answer the technical question but there is a whole bunch of premises in that question, which I would like to tackle, if I might.

Senator McLUCAS: I understand that the US federal drug agency has banned the sale of non-tamper proof formulations of oxycodone and I am asking whether the TGA is considering removing non-tamper proof formulations from the ARTG.

Prof. Skerritt: Clearly, prescription opioid abuse and diversion—this is diversion from abuse—is a serious public health issue and a serious addiction medicine issue. On the particular subject of these tamper-proof forms of oxycodone, our regulatory framework is different—

Prof. Halton: To the US.

Prof. Skerritt: to that of the US. In Australia a product can only be removed from the ARTG if, through normal use or use as indicated in the product information and as reviewed during the registration of the medicine, the benefit risk ratio changes—in other words, if risks start to counterweigh or exceed the benefits. This is not normal use of that product. I would say more broadly that there is also the need to consider a risk of other issues, including the potential for diversion into other opiates such as heroin or, even more worryingly, fentanyl which has a very small difference between the dose that is effective and gives a high and a dose that can kill you. We have asked the hospitals who are dealing with these diverting addicts and other users to actually monitor the incidents of diversion. Unfortunately and sadly, the initial evidence that has been given to us shows that there are more people coming in taking alternative opiates, so we have to be careful in concluding that this is a panacea.

Senator McLUCAS: I was not implying that it was a panacea. So there is no consideration being taken of the power that you have to ban the listing on the ARTG.

Prof. Skerritt: We are considering options all the time with every medicine when there are issues. What I did say was that our regulatory framework is different from that of USFDA's, and FDA are able to consider such issues as diversion for abuse.

It is also useful to note that FDA have tended to move away from this as their main approach to managing long-acting medicines and potent opioids. In fact, the FDA chose not to put the most recently approved FDA-approved opioid into an abuse-deterrent form. I think there is a growing recognition that this is a useful technology but, as I said before, it is not a panacea.

Senator McLUCAS: I understand that the tamper-proof intellectual property will be available for purchase by manufacturers of OxyContin currently using the tamperable formulation—that is an avenue available.

Prof. Halton: That is called 'a company wishes to actually make some money from their IP'. I think it is fair to say that everyone has been detailed by this company in respect of this issue—including, clearly, the journalist, and hence that piece in today's newspaper, which was explicitly aimed at this meeting. Let us be really clear about it.

Senator McLUCAS: I haven't seen that.

Prof. Halton: Well, it was. I think, as Professor Skerritt says, this is a very complex issue. There is firstly the question of our regulatory frameworks and what powers we have, and we are not the same as the United States, so it has been suggested by the proponents that we should just ban all these other versions. Under our current regulatory frameworks that is actually quite difficult for us. Then they have suggested that this will be the solution to diversion. Professor Baggoley can take you through some of the numbers that we know, because there is a hiatus at the moment. The tamper-proof version is on the market. The generic approval, which is what they are going to, does not actually come through potentially for another couple of months. We can see, in the data—particularly in Sydney—the increase in numbers of people presenting who have actually diverted to other products. It is fair to say that these numbers are quite worrying. There are also issues in respect of the appropriate utilisation of the most suitable drugs. Professor Baggoley can also go to this issue, given emergency medicine is his specialty. This will be his third start for the day; he is having a good day today. I might get Professor Baggoley to give you a little bit of that context. This issue is not as simple as it looks.

Prof. Baggoley: Thank you. John proposed to talk to the information we received late last week, specifically. Are you comfortable with that?

Prof. Skerritt: Yes.

Prof. Baggoley: We have received advice from a very important source, Dr Marianne Jauncey, who is the medical director of the Sydney Medically Supervised Injection Centre, which performs a very important function within Sydney for those who are injecting drug users. They are also able to have good data. They have been following the use of so-called tamper-proof oxycodone in recent months. As John Skerritt has mentioned, there is a concern that while you may be able to do something—and we will come back to what has been done in relation to the oxycodone to make it so-called tamper-proof—it might mean that people who still want to inject drugs will go to other drugs. He mentioned fentanyl. Fentanyl is a very short-acting opioid but there is not much gap between a dose that gives you a high or a dose that could kill you, as John has pointed out. The MSIC has noted that in the last few weeks there have been 25 fentanyl self-administrations per week compared with a baseline of five to six per week in February to March prior to the introduction of abuse-deterrent oxycodone. Comparative figures for heroin are 360 a week after versus 230 a week before, and for morphine 130 per week after and 45 per week before. What they are finding is that, while there has been a move away from oxycodone, there has been a move towards these other drugs, and they have gone on to say, 'As expected, the rates of overdose'—of course,

they can monitor these things and rescue people—'have increased from an average of six per 1,000 injections up to eight per 1,000'. So there has been an increase in overdose as a direct result.

Interestingly, and this too is important, we had Dr Jauncey—I spell it out for Hansard!—note however that 'Just in the last couple of weeks we are seeing small numbers of people who are now presenting and who seem to have found a way to successfully inject. They are reporting that the effects are comparable to the early formulation.' These are people who are successfully interjecting the tamper-proof or abuse-deterrent oxycodone. He continued, 'This is of concern to me, given the contradicting information that I had received from Mundipharma was that they were able to prepare the tablet quite quickly and that there was no gel formed, which is what they were advised. Their final solution was not the thick, viscous, glue-like substance that I understood it would be, but rather a slightly oily but easily injectable liquid.'

So on a number of levels there is a lot to be looking at with this. The phrase 'hillbilly heroin' which is being used by the Mundipharma company in writing to government and police commissioners and others is something that tends to focus just on oxycodone when you have to look at the whole range of options that are available.

There was a very good article in the National Prescribing Service in the May 2014 edition on this very topic. They put pointed out that the primary route of abuse has not changed—it is still the oral route. Whether it is abuse deterrent or not, it is still the oral route. They also encouraged GPs to stick better to the already published guidelines about the use of long-acting opioids. For cancer pain, it is recommended but it is not for noncancer pain.

What has been found early on is that those who do wish to divert and inject these drugs are finding a way to inject the abuse-deterrent form. Others are choosing different forms of opioid to inject with a greatly increased risk to their health.

Senator McLUCAS: Minister, have you had a formal briefing on the inappropriate use of OxyContin?

Senator Nash: The inappropriate—

Senator McLUCAS: Use of OxyContin.

Senator Nash: What do you mean by 'inappropriate use'?

Senator McLUCAS: People not using it for pain as a result of cancer but using it for recreational activities?

Senator Nash: I have certainly been advised by the department of the alternative forms apart from clinical need. I have actually had a range of discussions right across this area. I would just reiterate that it is complicated. As the secretary indicated earlier, we have a different set of arrangements to the United States. My understanding is that they did not have a generic on the market or coming onto the market. The other thing also to keep in mind is clinical need. There are patients who cannot utilise this drug for various reasons in the tamper-resistant form. So I would just reiterate that this is complicated; this is not a straightforward situation, as some might like to put it as being.

Senator McLUCAS: For the record: I did not realise there was an article in the paper this morning.

CHAIR: We do need to move on to FSANZ now.

Food Standards Australia New Zealand

[22:38]

CHAIR: Senator Xenophon, do you have any questions for FSANZ?

Senator Nash: What sort of question is that? He always—

Senator XENOPHON: What sort of question is that? That is right!

CHAIR: Go for it!

Prof. Halton: You could surprise us one day, Senator!

Senator XENOPHON: No. Despite the Prime Minister, I believe in no surprises.

CHAIR: You would possibly be disappointed!

Senator XENOPHON: I was being a little sarcastic then.

Prof. Halton: Yes, so was I.

Senator XENOPHON: Mr McCutcheon, obviously, I will put some of these on notice. But in the February estimates hearings I put questions on notice to FSANZ regarding levels of carbendazim in orange juice imports. My questions were referred in part to the Department of Agriculture. They informed me that had instituted the Imported Food Inspection Scheme. What role does FSANZ then play in identifying and monitoring foods that pose a medium to high risk to human health and safety?

Mr McCutcheon: I guess we have a couple of roles. One is we conduct regular surveys of the food supply chain, and if any particular chemicals in food present as a potential problem then we will advise the Department of Agriculture. They, in turn take that into account in their settings for imported food. Secondly, in terms of imported food specifically, the Department of Agriculture will seek advice from us on particular food safety risks, whether they are chemical or microbiological.

Senator XENOPHON: Just to clarify that, FSANZ is notified by the Department of Agriculture of noncompliance with Australian food standards?

Mr McCutcheon: FSANZ is not routinely notified of noncompliance with food standards. That is really a matter for the Department of Agriculture at the border and, more often than not, the relevant state or territory jurisdiction where that food may be sold.

Senator XENOPHON: Not routinely, but you may be notified on an ad hoc basis.

Mr McCutcheon: From time to time. I guess it depends on the particular issue that has been identified at the border. If it requires some scientific assessment or advice from FSANZ then the agriculture department—

Senator XENOPHON: That means that FSANZ does not have any direct role in enforcement or recalls of noncompliant products?

Mr McCutcheon: We do not have any role in enforcement. We do have a role in coordinating national recalls of food when they are required.

Senator XENOPHON: I will put some further questions on carbendazim on notice. I want to go from orange juice to raspberries. I am trying to give Professor Halton a bit of variety.

Prof. Halton: Excellent. We approve of that.

Senator XENOPHON: In the previous estimates hearings, I also put questions on notice regarding a *Today Tonight* report which revealed banned chemicals in imported frozen raspberries. The program found a number of brands contained traces of a number of fungicides and pesticides, some of which are banned here in Australia. Has FSANZ conducted a risk assessment regarding imported frozen raspberries and, if so, what were the results?

Mr McCutcheon: Not to my knowledge, no.

Senator XENOPHON: Can you take that on notice? In response to my questions on notice, FSANZ informed me that they had responded to inquiries about maximum residue limits for various chemicals used on berries including raspberries. On notice, can you tell us what the MRLs for berries including raspberries are? I think the questions on notice are a bit different from the answer you just gave.

The Department of Agriculture has informed me that the Imported Food Inspection Scheme does not assess the food safety implications where a chemical residue is found in food. Does FSANZ assess food safety implications of chemical residue found in food?

Mr McCutcheon: When we establish the maximum residue limit in the Food Standards Code, then food safety and public health and safety is the primary consideration as we go about that. Again, if you are talking about individual cases, we would conduct an assessment if the Department of Agriculture requests that we do so.

Senator XENOPHON: That happens as a matter of course, if it is requested?

Mr McCutcheon: If it is requested, yes, we would undertake that. That is a function we have under our act.

Senator XENOPHON: I just want to get some clarity here. In my previous questions on notice I asked if FSANZ had been made aware of the results of independent investigations by Coles and Woolworths. FSANZ informed me that they would not have been made aware of these results and that such results would normally be provided to state and territory enforcement agencies rather than FSANZ. However, the FSANZ website states:

FSANZ coordinates and monitors food recalls in Australia.

It also says:

FSANZ helps food businesses to recall unsafe food in Australia by communicating recall information to the state and territory government agencies and industry groups.

Can you clarify that? If FSANZ coordinates food recalls, shouldn't these results be provided to FSANZ initially?

Mr McCutcheon: They would only be provided to FSANZ if there was a need for a food recall to take place. Generally the enforcement activities of states, where they identify noncompliance with the Food Standards Code, are not public health and safety issues. But where they do identify a public health and safety issue associated with chemical residues in food, and it is of sufficient gravity to justify a recall, then that particular jurisdiction will initiate the recall and FSANZ will coordinate the national arrangements.

Senator XENOPHON: Finally, I would like to put some questions on notice about banned or potentially unsafe chemicals identified in food products at levels below the MRL. There are products that cannot be used in Australian agriculture, such as carbendazim. If they are identified in food products, does FSANZ consider that consumers ought to be aware of the potential presence of these chemicals, given that they are not permitted for use by Australian farmers by another agency in the context of Australian grown products?

Mr McCutcheon: If I understand your question, I think our interest in this would be limited to making sure that there are particular chemical commodity combinations or residue limits in the code. Once that is established, then it would be up to the enforcement agencies to check that particular food against that MRL in the code.

Senator XENOPHON: So even though it cannot be used by Australian farmers, the fact that it is in imported products below the MRLs is of no interest?

Mr McCutcheon: The MRLs that are in the Food Standards Code relate to the sale of food. In terms of whether chemicals are approved for use in Australia or not, that is a separate area of government regulation.

Senator XENOPHON: I will put some of these other questions on notice.

CHAIR: I think you managed to do that without eating into your extra minute.

National Industrial Chemicals Notification and Assessment Scheme

[22:45]

CHAIR: We will move now to NICNAS, who are the last people of the evening.

Senator McLUCAS: Can we talk about the chemicals used in fracking or coal seam gas extraction? I understand that the former government provided funding to NICNAS to expedite the assessment of chemicals use in CSG mining. What was the specific purpose of that funding?

Dr Richards: The Australian government provided $4.2 million for a national assessment of the chemicals used in CSG extraction in Australia, and the purpose of that was to examine the human health and environmental risks from chemicals used in drilling and hydraulic fracturing for CSG extraction in Australia, and to also identify chemicals that are mobilised from the coal seams by the fracturing process.

Senator McLUCAS: How much funding has been allocated to that?

Dr Richards: $4.2 million was allocated in total.

Senator McLUCAS: How is it being used over time is what I am asking.

Dr Richards: The funding does not all go to NICNAS, regrettably. This is a joint project between NICNAS, the Department of the Environment, CSIRO and with Geoscience Australia on as an adviser. Each of those agencies is undertaking different components of the project. All of this work is actually being funded through the environment portfolio, and so the reports will go to the environment department and will be released following discussion between the environment minister and Assistant Minister for Health, Senator Nash.

Senator McLUCAS: What are the reports that you are expected to be able to produce?

Dr Richards: The primary report that is being provided by NICNAS is a risk assessment of the chemicals being used; that will be the final report. The way risk assessments are undertaken is firstly to clearly identify the chemicals that are being used. We are identifying the chemicals that are being used through a range of strategies, including a survey of industry players, as well as information obtained from companies' websites and other publicly available sources. The way we use the term hazard relates to the intrinsic properties of the chemical, so, once we have identified the chemicals, we then do research to identify the known hazards, which relate to the characteristics of the chemical. We then we look at the exposure related to the use of the chemical, and how exposure to humans and the environment takes place, and then we can understand the risk to human health and the environment and make recommendations to promote safer use.

As Paracelsus, the father of toxicology in the Renaissance, said: 'The dose makes the poison.' Even with a commonly used, benign chemical like hydrogen oxide, often named water, you can die from an overdose. It comes down to the dose to humans, either the general public or workers in that industry, or to the environment. So we look at the hazard, the exposure and the use and then we work out the risks. That would be the primary output from us to the environment department.

Senator McLUCAS: When is it expected that that report will be available?

Dr Richards: We expect all those reports to be delivered in the second half of this calendar year, so early in the next financial year.

CHAIR: Senator Rhiannon, you have five minutes.

Senator RHIANNON: Dr Richards, can you confirm that NICNAS accepts non-animal test data on cosmetics or their ingredients that are generated in accordance with standard test methods such as the European Commission directive?

Dr Richards: The data requirements for assessing new chemicals by NICNAS are set out in our act and associated regulations. NICNAS's data requirements are largely based on those established by the OECD, the Organisation for Economic Cooperation and Development, which sets out a range of guidelines for conducting toxicology tests. The OECD has recognised and formalised test guidelines for a range of toxicological end points which do not involve the use of animals. Where those guidelines are in place and those non-animal tests have been validated, NICNAS accepts those test results in complete substitution for any animal test data. What we look for is data that provide us information on particular toxicology end points, like acute toxicity and repeat dose toxicity, and where non-animal tests have been validated NICNAS accepts those test results.

Senator RHIANNON: If a ban on animal tested cosmetics or their ingredients explicitly does not apply to an ingredient in cosmetics, if the ingredient is a therapeutic good within the meaning of the Therapeutic Goods Act, would NICNAS be satisfied this would mean medicines would not come under the ban on animal tested cosmetics?

Dr Richards: I believe that is a hypothetical question—

Prof. Halton: Which we do not answer.

Dr Richards: and I am not in a position to answer.

Senator RHIANNON: Okay. Can NICNAS confirm if the following fall under the meaning of cosmetics in the IC(NA) Act—and I am just after yes or no answers. Household cleaning products?

Dr Richards: No.

Senator RHIANNON: Veterinary products or animal health products?

Dr Richards: No.

Senator RHIANNON: General industrial chemicals?

Dr Richards: No.

Senator RHIANNON: Food?

Dr Richards: No.

Senator RHIANNON: The industry body Accord Australasia Ltd has circulated material that asserts that NICNAS currently mandates by law that companies provide animal test data for local assessment of new ingredients or existing ingredients under safety review. Does NICNAS mandate by law that companies provide animal test data for local assessment of new ingredients or existing ingredients under safety review?

Dr Richards: I need to be careful in answering that question. NICNAS does not mandate anything by law. Parliament, as I understand it, passes the laws and NICNAS administers the laws as passed by parliament. The IC(NA) Act and associated regulations that have been enacted by the parliament do, at first glance, require certain data to be substantiated by animal testing, but the act also allows companies to apply to NICNAS for a variation of those data requirements and those data requirements are very frequently varied by NICNAS.

I think it is fair to say that NICNAS has never insisted that a company conduct tests on animals in order to provide data. NICNAS assesses a chemical based on the data that are able to be provided by a company. Clearly, if a company cannot provide sufficient data to allow a confident risk assessment to be undertaken then the restrictions that might be recommended by NICNAS to manage the associated uncertainty might be more onerous than conditions that might apply were a risk assessment able to be carried out with more precision.

CHAIR: Last question, Senator Rhiannon.

Senator RHIANNON: I just want him to finish that. Dr Richards, can you just finish that, thank you. Sorry.

Dr Richards: I think I finished it.

Senator RHIANNON: Thank you, Dr Richards; that was very helpful..

CHAIR: Senator Xenophon.

Senator XENOPHON: Dr Richards, in the NICNAS report *Inventory Multi-Tiered Assessment and Prioritisation(IMAP)—human health tier II assessment for benzidine-based dyes*, it says that Australia had 'no exposure standards', page 8, and 'no restrictions', page 9, on the chemicals of azo dyes and:

In the absence of any regulatory controls, the characterised critical health effects (particularly carcinogenicity) have the potential to pose an unreasonable risk—

to public health. In the view of NICNAS, or the Minister for Health, what more needs to be done in Australia in relation to the regulations, in relation to Customs and in relation to product and consumer safety to ensure that azo dyes do not pose such an unreasonable risk, as you categorise, to the public.

Dr Richards: The Industrial Chemicals (Notification and Assessment) Act 1989, commonly referred to as the ICNA Act, establishes a framework for assessing chemicals and generally requires NICNAS to make recommendations that would render risks associated with the use of chemicals acceptable where, without those recommendations, the uses might be deemed to be unacceptable. In the case of the assessment report on the benzidine based dyes, NICNAS did make recommendations—did find that, in the absence of other controls, the risks would be unacceptable. There were two primary recommendations that were made that are contained in that report. The first was that the delegate of the secretary responsible for scheduling under the poison standard ban, effectively, the use of these dyes in home based dyeing products, and that has occurred; and from this month—

Senator XENOPHON: As of yesterday, 1 June.

Dr Richards: as of Sunday—those dyes are now prohibited for home based use.

Senator XENOPHON: But they are not prohibited for imports that contain these dyes, correct?

Dr Richards: That is correct, Senator. So the second recommendation made by NICNAS was to the ACCC, which was that where products that are used by consumers might result in the prolonged exposure of the consumer to those dyes in an article—

Senator XENOPHON: Yes, like wearing them.

Dr Richards: like wearing them, or having them in blankets or sleeping in them—

Senator XENOPHON: Blankets; that is right.

Dr Richards: the ACCC should take sufficient steps to ensure that those—

Senator XENOPHON: In the remaining minute and a half or 10 minutes, depending on the generosity of the chair, does the scheduling of azo dyes by the TGA bring Australia up to par in comparison with controls in Europe, for instance? Do you want to take that on notice?

Dr Richards: I would take that on notice.

Senator XENOPHON: Please. So what more, in the view of NICNAS, would need to happen in Australia for us to meet the same conditions as those in Europe in relation to limiting exposure to azo dyes?

Dr Richards: In answer to that question, I would say that NICNAS, in making its recommendations, makes recommendations in the framework in which Australian public health, workers health and environmental controls are available. So we need to cut our cloth to make the suit!

Senator XENOPHON: Depends if the cloth has azo dyes in it!

Dr Richards: We do, indeed, Senator. Very droll!

Senator XENOPHON: That is right. So the European—

Dr Richards: We do not aspire to implement European controls if they do not suit our regulatory environment. So we make—

Senator XENOPHON: Yes, but presumably European skin is similar to Australian skin, isn't it, in terms of it absorbing dyes?

Dr Richards: The European regulatory system is not the same as the Australian regulatory system. So we make recommendations to the relevant regulators that will result in there being no unreasonable risk to Australia.

Senator XENOPHON: Can I just rattle these off to put them on notice. Firstly, what was the context of the NICNAS assessment of azo dyes and what further work is being done in relation to azo dyes in Australia? Secondly, the European Union, in my view, is a long away ahead of Australia in terms of identifying, regulating and blocking the importation of literally thousands of chemicals hazardous to human health into Europe. Finally, what other groups of dangerous chemicals that pose an unreasonable risk to the public health is NICNAS intending to assess as to Australians' exposure, hazard potential and risk to public health. Chair, I have got 20 seconds left! Do you want me to slip in something else?

CHAIR: Goodness! Should I just suspend while we have got time, do you think, Senator Xenophon!

Senator XENOPHON: No, I would be grateful if I could get some answers to those questions. Thank you very much. I have cut my cloth accordingly!

CHAIR: Thank you very much, Senator Xenophon—beautifully done. We will adjourn now and resume at nine o'clock tomorrow morning with outcome 8, healthcare workforce capacity. Could I just thank all the officers who came along and gave evidence today. Professor Halton and Professor Baggoley, I will see you tomorrow.

Prof. Halton: See you tomorrow. That is exactly right.

Committee adjourned at 23:00