COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Estimates

TUESDAY, 2 JUNE 2015

CANBERRA

BY AUTHORITY OF THE BY AUTHORITY OF THE SENATE

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Tuesday, 2 June 2015

Members in attendance: Senators Bernardi, Carol Brown, Di Natale, Leyonhjelm, Marshall, McLucas, Moore, Peris, Polley, Reynolds, Ruston, Seselja, Siewert, Smith, Waters, Xenophon. Marshall, McLucas, Moore, Peris, Polley, Reynolds, Ruston, Seselja, Siewert, Smith, Waters, Xenophon.

HEALTH PORTFOLIO

In Attendance

Senator Nash, Assistant Minister for Health

Department of Health

Whole of Portfolio

Mr Martin Bowles PSM, Secretary

Professor Chris Baggoley, Chief Medical Officer

Ms Liz Cosson, Deputy Secretary

Mr Mark Cormack, Deputy Secretary

Mr Chris Reid, Legal and General Counsel

Mr Andrew Stuart, Deputy Secretary

Dr Wendy Southern, Deputy Secretary

Mr Paul Madden, Special Adviser

Adjunct Professor John Skerritt, Deputy Secretary and National Manager, Therapeutic Goods Administration

Mr Colin Cronin, Assistant Secretary, Audit and Fraud Control

Ms Mary McDonald, First Assistant Secretary, Best Practice Regulation and Deregulation Division

Ms Kate Pope, First Assistant Secretary, Grant Services Division

Mr Lou Andreatta, Assistant Secretary, Grants Process and Policy

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

Dr Richard Bartlett, First Assistant Secretary, Portfolio Investment Division

Ms Alanna Foster, First Assistant Secretary, Portfolio Strategies Division

Mr Simon Cotterell, Assistant Secretary, International Strategies Branch

Ms Janet Anderson, First Assistant Secretary, Acute Care Division

Mr Charles Maskell-Knight, Principal Adviser, Acute Care Division

Dr Andrew Singer, Principal Medical Adviser, Acute Care Division and Health Workforce Division

Ms Kylie Jonasson, First Assistant Secretary, Office of Health Protection

Ms Kerry Flanagan, Director, Australian Institute of Health and Welfare

Mr Andrew Kettle, Group Head, Business and Governance

Outcome 1

Ms Elizabeth Flynn, Acting First Assistant Secretary, Population Health Division

Ms Kylie Jonasson, First Assistant Secretary, Office of Health Protection

Mr Graeme Barden, Assistant Secretary, Health Protection Policy Branch

Ms Kirsty Faichney, Assistant Secretary, Immunisation Branch

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

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

Professor John McCallum, Chief Science Advisor, Dementia Research

Mr Tony Kingdon, General Manager, Research and Operations Group

Ms Samantha Robertson, Executive Director, Research and Operations Group

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

Dr Marion Healy, Deputy Chief Executive Officer and Chief Scientist

Dr Scott Crerar, Section Manager, Scientific Strategy, International and Surveillance

Dr Craig Duncan, Manager, Risk Assessment – Microbiology Section

Professor Helen Zorbas AO, Chief Executive Officer, Cancer Australia

Outcome 2

Ms Felicity McNeill, First Assistant Secretary, Pharmaceutical Benefits Division

Outcome 3

Mr Shane Porter, Acting First Assistant Secretary, Medical Benefits Division

Ms Janet Anderson, First Assistant Secretary, Acute Care Division

Mr Charles Maskell-Knight Principal Adviser, Acute Care Division

Dr Andrew Singer, Principal Medical Adviser, Acute Care Division and Health Workforce Division

Outcome 4

Ms Janet Anderson, First Assistant Secretary, Acute Care Division

Mr Charles Maskell-Knight Principal Adviser, Acute Care Division

Dr Andrew Singer, Principal Medical Adviser, Acute Care Division and Health Workforce Division

Mr James Downie, Acting Chief Executive Officer, Independent Hospital Pricing Authority

Outcome 5

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

Ms Maria Jolly, First Assistant Secretary, Indigenous and Rural Health Division

Ms Meredeth Taylor, Assistant Secretary, Rural, Remote and Indigenous Access Branch

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

Outcome 6

Mr Shane Porter, Acting First Assistant Secretary, Medical Benefits Division

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

Mr Paul Groenwegen, General Manager and Deputy Chief Executive Officer

Mr David McGregor, Private Health Insurance Ombudsman

Mr Neil Smith, General Manager, Industry Operations, Private Health Insurance Administration Council

Outcome 7

Ms Bettina Konti, First Assistant Secretary, eHealth Division

Ms Linda Jackson, Assistant Secretary, eHealth Policy Branch

Mr Matt Corkhill, Assistant Secretary, eHealth System Operations Branch

Ms Kylie Jonasson, First Assistant Secretary, Office of Health Protection

Mr Graeme Barden, Assistant Secretary, Health Protection Policy Branch

Ms Janet Anderson, First Assistant Secretary, Acute Care Division

Mr Charles Maskell-Knight Principal Adviser, Acute Care Division

Dr Andrew Singer, Principal Medical Adviser, Acute Care Division and Health Workforce Division

Ms Elizabeth Flynn, Acting First Assistant Secretary, Population Health Division

Ms Felicity McNeill, First Assistant Secretary, Pharmaceutical Benefits Division

Ms Alana Foster, First Assistant Secretary, Portfolio Strategies Division

Mr Simon Cotterell, Assistant Secretary, International Strategies Branch

Dr Brian Richards, Executive Director, Office of Chemical Safety and Director

Adjunct Professor John Skerritt, Deputy Secretary and National Manager, Therapeutic Goods Administration

Dr Tony Gill, Acting Principal Medical Adviser

Ms Judy Develin, First Assistant Secretary, Regulatory Support Division

Dr Larry Kelly, First Assistant Secretary, Monitoring and Compliance Division

Dr Lisa Studdert, First Assistant Secretary, Market Authorisation Division

Ms Philippa Horner, Principal Legal Adviser,

Ms Nicole McLay, Assistant Secretary, Regulatory Business Services Branch

Ms Yael Cass, Chief Executive Officer, Organ and Tissue Authority

Ms Judy Harrison, Chief Financial Officer

Dr Helen Opdam, National Medical Director

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

National E-Health Transition Authority

Chief Executive

Outcome 7: Health Infrastructure, Regulation, Safety and Quality

Program 7.1: e-Health

Mr Peter Fleming, Chief Executive Officer

Outcome 8

Ms Penny Shakespeare, First Assistant Secretary, Health Workforce Division

Dr Andrew Singer, Principal Medical Adviser, Acute Care Division and Health Workforce Division

Outcome 9

Ms Kylie Jonasson, First Assistant Secretary, Office of Health Protection

Mr Rob Cameron, Assistant Secretary, Health Emergency Management Branch

Mr Graeme Barden, Assistant Secretary, Health Protection Policy Branch

Dr Gary Lum, Specialist Medical Advisor, Office of Health Protection

Outcome 10

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

Mr Simon Hollingsworth, Chief Executive Officer, Australian Sports Commission

Mr Matt Favier, Director, Australian Institute of Sport

Ms Fiona Johnstone, Chief Financial Officer

Mr Michael Thomson, General Manager, Participation and Sustainable Sport

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

Mr Trevor Burgess, National Manager, Operations, Australian Sports Anti-Doping Authority

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

Mr Patrick Walker, Chief Executive Officer, Australian Sports Foundation

Department of Health

Committee met at 09:01

CHAIR (Senator Seselja): We will recommence. Welcome back, Minister. Welcome, Mr Bowles, Mr Stuart and officials.

Senator DI NATALE: I have some questions that relate to the issue of the pharmacy agreement. No doubt you are aware of the Audit Office report into the Fifth Community Pharmacy Agreement and we now have an agreement to expend money under the Sixth Community Pharmacy Agreement. I am still a little unclear about the process of how this is all done and I would like to ask some questions around that. What role do you, as secretary, have in the negotiations and administration of the community pharmacy agreement?

Mr Bowles: From the perspective of my being the secretary of the department, I am the accountable officer in the department for anything that goes on. As for the role I played, I met with a lot of the stakeholders. We started, I think, on 12 February with an all-stakeholder forum that set the tone for negotiating the pharmacy agreement. The officials, being Mr Stuart and Ms McNeill, did most of the leg work, obviously. Then I participated in a range of conversations with some of the players as we went through the process.

Senator DI NATALE: So it was a pretty hands-on sort of role?

Mr Bowles: Yes, reasonably so.

Senator DI NATALE: Can I ask you then about the Audit Office report into the Fifth Community Pharmacy Agreement? The Audit Office was very critical of the department. It

listed a number of accounting and probity issues, record keeping failures and a number of issues of concern. What did you do in order to respond to the Audit Office report? Can you take me through the steps that you went through in response to that report?

Mr Bowles: I will get Ms McNeill to go to the detail. But, broadly, when you get an ANAO audit outcome that actually goes through and provides some quite serious recommendations about how you need to act, you take notice of that and you build that into your procedures; you build that into, basically, your modus operandi. Ms McNeill can take you through effectively what she did—because she runs the pharmaceutical benefits division—in dealing with the new arrangements but understanding how things may have happened in the fifth agreement and what we did differently, if you like, in relation to the new agreement because of the Audit Office report on the fifth.

Ms McNeill: There were, of course, eight recommendations stemming from the ANAO's review of the Fifth Community Pharmacy Agreement. I think probably the easiest way for me to do that is to go through the eight recommendations and how we have responded to them in the Sixth Community Pharmacy Agreement to provide some assistance to the committee. Recommendation No. 1 was asking us to clarify the nature of financial commitments entered into by the Australian government and recommended that key documents—estimated government payments and patient subsidies—be clearly articulated.

So within the Sixth Community Pharmacy Agreement we have implemented a systems enhancement to ensure our financial modelling software separates these estimates and these costs. In keeping with the ANAO's recommendations, we have identified in the Sixth Community Pharmacy Agreement the estimated government and patient remuneration contributions for both subsidised and unsubsidised PBS and RPBS scripts. For ease of reference for the committee, that is in clauses 3.3 to 3.5 of the Sixth Community Pharmacy Agreement. We also have other relevant remuneration elements clearly included, such as chemotherapy preparation fees and fees associated with the new initiatives for distribution of the National Diabetes Services Scheme products by pharmacists, which is in clause 3.4, table 2.

Senator DI NATALE: Could I just interrupt for a moment because I suspect that you are going to provide me with a long list and I do not know that it is going to be particularly helpful to me in terms of answering the questions. Could we do this perhaps a little back to front? I might just ask you about some of the criticisms and concerns and then you might point me to the changes that have been made that address those concerns rather than going through the recommendations; is that okay?

Mr Bowles: We are happy to do that, but I suppose the point that I will make is that we took the audit outcome very seriously.

Senator DI NATALE: Good.

Mr Bowles: And, as Ms McNeill was going through there, this is a significant issue and we wanted to make sure that we got it right. We are happy to respond to your question; that is probably the easiest way, I think.

Senator DI NATALE: I am pleased.

Mr Bowles: We could talk about this for a while because it has been front of mind, of course.

Senator DI NATALE: Good; I am pleased that it has. I suppose one of the big issues was that the Auditor found that a decision not to prepare an official record of discussions in the negotiating of the fifth agreement was not consistent with sound practice. The question is: firstly, was there any reason that that happened; and, secondly, how did we change that in negotiating on the Sixth Community Pharmacy Agreement?

Ms McNeill: I can respond to the Sixth Community Pharmacy Agreement, but I would have to look to my colleagues here on the Fifth Community Pharmacy Agreement.

Mr Bowles: I will just make a comment on the fifth: I was not there either, but I suppose it is what it is. There was an audit outcome that said a whole range of things that we could have done better. We are moving forward. We have accepted the recommendations and we have implemented them in the context of how Ms McNeill was dealing with the sixth. Perhaps we can focus on the sixth and, if you have any residual issues around the fifth, we will see if we can find someone to answer any of those fifth questions for you.

Senator DI NATALE: Is it okay if we do that now?

Mr Bowles: The fifth?

Senator DI NATALE: Yes. I will do both together; that is probably the easiest.

Mr Bowles: We will see what we can do about the fifth, because not a lot of us were around at that particular point. It was five years ago.

Senator DI NATALE: Okay.

Mr Stuart: I have a little knowledge. I can perhaps help a little bit at a high level, but we will see.

Senator DI NATALE: Okay.

Mr Bowles: Getting down into the detail of what happened or did not happen in the fifth is going to be a little bit difficult for us, that is all.

Mr Stuart: In answer to the first part of your question, I guess I would say that, during the negotiation of the Fifth Community Pharmacy Agreement, there was a small group of staff working under considerable pressure in a short time frame who apparently took the view that this was a kind of policy exchange that was occurring with the Pharmacy Guild. I think the audit was very clear in putting that much more inside a purchasing framework. I think what we have learned from that and what Ms McNeill has very effectively implemented is a set of procedures that are much more tender-like and negotiation-like in their structure than a kind of policy discussion.

Senator DI NATALE: I do not really understand what you mean by 'policy discussion'. I take your point that the framework has changed, but what do you mean by that?

Mr Stuart: There was not—and the audit makes this clear—probity advice, there was not a lawyer in the room and there was insufficient note taking. The view, I think, appears to have been taken that it was the end product of the written agreement that was the key document that summed up and was the final product of all of the work and that that was the important document rather than documenting the pieces of negotiation along the way. I am interpreting what I understand from what happened, not being very close to it, and from the audit, but that seems to me to have been the fundamental issue.

Mr Bowles: We took quite a bit of notice of the broader issues and that is why we set the stage on 12 February for a meeting with a range of players from RACGP to the AMA, to the guild, to Medicines Australia, to GMiA and to the consumer groups—there were a few others in the room—which basically was the minister saying, 'We're about to start negotiations on the sixth pharmaceutical agreement; we want input across, if you like, the supply chain or the life cycle'—however you want to describe it—'of this agreement.' That is how we started this process, which was quite different to the fifth—and, quite frankly, I think it was quite different to the first, second, third, fourth and fifth—in how we actually approached this. Now, part of that was in response to the audit of the fifth and part of it was in the broader approach to how you do negotiations and how you engage the supply chain in a conversation about a very, very complex set of issues.

Senator DI NATALE: I suppose that it is one thing to have a discussion with those groups; it is another thing to involve those groups in the detail of the negotiations.

Mr Bowles: Yes.

Senator DI NATALE: I think that is where some of the criticism has come in from some of those groups: while they have been involved in preliminary discussions in the early stages, when it actually comes to signing on to the agreement, there were in fact only a couple of players in the room.

Mr Bowles: Let me make it clear. The agreement is between the guild and the government, and the fact that we have a whole range of arrangements in place with other parties this time for other pieces of the supply chain is something that has never been done. When you do open things up to have a broader consultation and a broader range of stakeholders, of course, you are going to get people who are not going to be totally happy because they were not met with every second day like some players. But, at the end of the day, this was a much more open and transparent process across a broad range of stakeholders, some of whom had never been involved and some of whom were probably only peripheral to the final outcome. But we were keen to make sure that they were part of a process at that point in time. I will accept that there were 20 different stakeholders, or something like that, that were engaged through this process and not everyone was met with the same number of times, clearly. The Pharmacy Guild, Medicines Australia, GMiA and some of the wholesalers, I suppose, would be the key groups, if you like, and they were front and centre in this arrangement.

Senator DI NATALE: I do not know if it was a good or bad outcome, to be frank. The concern I have is that we are talking almost $20 billion—$19-and-a-bit billion dollars—of taxpayer funds. It is a huge area of government expenditure and it still is a bit of a black box to those of us sitting over here as to how those funds are expended and how the agreement is reached. When you have a report like the ANAO report which is so critical of the previous agreement—

Mr Bowles: Let me make—

Senator DI NATALE: I am asking the questions not for any other reason but to know that we have confidence that there—

Mr Bowles: I totally accept that. I actually absolutely agree with you. But let me make the point: the fifth pharmacy agreement was five years ago. There was an audit done on it and we—

Senator DI NATALE: Which was released, what, only about six months ago?

Mr Bowles: Not even that, I think. It was in the middle of—

Ms McNeill: It was three months ago.

Mr Bowles: Three months ago.

Senator DI NATALE: So three months ago.

Mr Bowles: We used that. It actually got released almost at the same time as we started this process. So, from our perspective, it was the perfect time so we could learn all of the lessons that came out of that particular process and feed them into the new process.

Senator DI NATALE: I understand that. But from my perspective what I see is a report that is absolutely damning—we won't mince words—of the Fifth Community Pharmacy Agreement. I do not think I have ever seen a report as critical of a department as this one was. Then we rush to sign on to the sixth agreement without any official response—this is from my perspective—from the department. I ask questions about this in the parliament. We do not get anywhere with it and the next we hear is that we have signed on to the Sixth Community Pharmacy Agreement. All I am trying to do is present to you the perspective that I come at this issue from. You can understand why I would have concerns—$15 billion and we have the Audit Office saying, 'This was a mess; it failed any basic standards of good governance' and then, as soon as a report comes out, we are in a rush to sign another agreement worth $19 billion.

Mr Bowles: Because a report comes out three months ago, it does not mean that we were not actively engaged with the ANAO through that process. I will go back to the things that were in question here, which were in relation to the striking of the fifth agreement, which was five years ago; it was 2010. So a whole lot of things have changed. We have learned how to deal with these issues. We had the ANAO report. Ms McNeill and her team were actively engaged with ANAO through that process. When you are actively involved with the ANAO—as I have been in many, many different things over the years—you help each other, you learn from the processes and you change your procedures. That has been happening for a long period of time. I am happy for Ms McNeill to answer any of your questions on the sixth, but I am saying that the fifth was a long time ago. I am not walking away from the recommendations. As you would see in the report, we have responded to the recommendations within the ANAO report, and we have accepted that we need to do better and we have incorporated that into the business that we run today.

Senator DI NATALE: I understand your perspective—you might have had the report earlier than it was released. I did not. Our job is to scrutinise the expenditure of $19 billion of taxpayer money. We have not had sufficient time to be able to do that; that is my concern. So I understand the perspective you are coming from, but understand from my perspective that we have the report released only a few months ago, it is damning, and then we see the department rushing in to sign on to another agreement.

Mr Bowles: We did not rush in to do anything. It is a five-year agreement. Changeover is 1 July. So we did not rush. We have worked methodically over a long period of time.

Senator DI NATALE: We have no capacity to be able to scrutinise that.

Mr Bowles: I am happy for you to ask Ms McNeill any questions you like on the Sixth Community Pharmacy Agreement.

Senator DI NATALE: We will move on to that. In terms of questions around the Fifth Community Pharmacy Agreement, there are a whole lot of questions that still, for me, are not answered and we will be looking for an opportunity to revisit some of those. But I accept your point that those of you here were not involved in negotiations at the time. Let me just ask a few basic questions about the agreement. Is it true to characterise the agreement as one where we have pharmacy getting a guaranteed 4½ per cent increase each year for five years? Does that accurately reflect the nature of the agreement?

Ms McNeill: It is not a fair reflection. I think context is important here. First of all, what we have done is introduced an administrative and handling infrastructure fee. This recognises that, over the life of the fifth agreement, the average remuneration for dispensing went down 16 per cent despite the fact that script volumes were increasing.

Senator DI NATALE: Let us be clear about that. So what a pharmacist gets for dispensing medicine, on average, is decreasing by—

Ms McNeill: Yes, for dispensing medicine, remuneration was decreasing by 16 per cent, on average.

Senator DI NATALE: What does that reflect in terms of an average income for a pharmacy; do you know? Can you put that in—

Ms McNeill: I can, I think. But I might just finish explaining to you what we did and why. This is excluding trading terms, which we all appreciate is a separate issue and is not official government remuneration. The average dispensing fee fell by 16 per cent over the life of the fifth agreement. What we have done under the sixth agreement is to ensure that the average dispensing fee over the life of the fifth is maintained in the sixth agreement with the indexation, which has moved from WCI9 to CPI.

Senator DI NATALE: In English, what is WCI9?

Ms McNeill: Wage cost index 9. This is consistent with the multiplier that we use on the PBS.

Senator DI NATALE: This is where I get a bit confused. The objective here is to ensure that we have remuneration—let us call it remuneration for pharmacists—keeping up with CPI over the life of the agreement. That is the sort of objective.

Ms McNeill: That is the objective, yes.

Senator DI NATALE: So why is it that, when it comes to general practice, we are freezing indexation for four years? Why do we have different treatment for different health professionals?

Mr Bowles: I think that is an unfair question to the officer.

Senator DI NATALE: Why is that unfair?

Mr Bowles: Because Ms McNeill has nothing to do with what happens in the medical benefits space or in the payment of GPs.

Senator DI NATALE: But why is it an objective to ensure that remuneration for pharmacists keeps up with CPI? Why is that a policy objective as far as the department is concerned, when it is not an objective for general practice?

CHAIR: Senator Di Natale, you are asking for an expression of opinion from—

Senator DI NATALE: No, no.

CHAIR: Well, you are. You are actually asking for an expression of opinion. You may want to couch it in a different way, but at the moment you are asking for an expression of opinion. We have made it clear that, in terms of Public Service—

Senator DI NATALE: So, I will not ask for an opinion. Does the department have an objective to ensure that the remuneration for pharmacists keeps up with CPI?

Mr Bowles: I will let Ms McNeill talk about some of the reasons here, and there are some differences between the two, clearly. However, we are talking about a complex set of issues here. At the moment we are talking about one of about 20 items that make up the pharmacy agreement—administrative handling, or AHI for shorthand. So we are talking about one component of the entire thing. That is one contextual point, but Ms McNeill can fill us in on some of the other issues.

Ms McNeill: The point is that we set remuneration for the pharmacy for five years. So it is fixed, and then it is not negotiated further. We recognised that, because the dispensing fee was relinked to the value of the medicine, it was pushing down the average dispensing fee. So, unlike simply a freeze on the dispensing fee, it was actually going backwards by the average of 16 per cent over the life of the Fifth Community Pharmacy Agreement. What we have sought to do is to delink remuneration from the price of the medicine so that we are not actually trying to deal with that issue. We are trying to make sure that, unlike a general practitioner or a specialist, when we set the price that is the maximum price that the pharmacist can charge for the service as opposed to the minimum price.

Mr Stuart: So there is a big distinction between the way the MBS operates and the way the PBS operates in this area. The PBS sets a ceiling on the prices that are then shared between the manufacturer and the wholesaler and the pharmacist. The MBS sets an amount that the patient is reimbursed and the price charged by the physician is uncapped, so there is also a clear distinction there.

Senator DI NATALE: I understand that difference and I do not want to—

CHAIR: Senator Di Natale, I do not wish to cut you off, but I know there are others waiting to ask questions. You are almost at 25 minutes, so I will go to others. We can come back, but I will give others an opportunity. So you can have a couple more questions and then we will move to others.

Senator DI NATALE: Yes. Eighty per cent of Medicare services are bulk-billed. While that might be a theoretical difference, in reality, given that 80 per cent are bulk-billed, I think it is fair to say that there is a freezing of indexation on health professionals in a very similar way. By the way, I am not arguing against what was the outcome of the community pharmacy agreement; I am just looking at the inconsistencies across different areas to examine whether there are—

Mr Bowles: I understand your point, but it is not something that Ms McNeill can really answer; that is more policy issues.

Senator DI NATALE: The additional $600 million for support programs for patients—could you outline what they are?

Ms McNeill: Certainly. They are yet to be formally developed. You referred earlier to the consultation process and how we were ensuring that those people that we consulted with to feed into the negotiations continue to be a part of the Sixth Community Pharmacy Agreement. It is something that we have heard from the stakeholders as well as from the ANAO. We will be establishing pilot programs based on the ideas of not only the community pharmacy sector—which is the guild, or the Pharmaceutical Society of Australia—but other stakeholders, such as consumers, the AMA, RACGP et cetera, about piloting programs that can demonstrate cost-effectiveness and health outcomes for patients. As to what those pilots will actually be, the first $50 million to pilot those is not yet clear. We will design that in consultation with a broad group of stakeholders. The Sixth Community Pharmacy Agreement makes that very clear. I think what is important to put on the record in this area is that those pilots will then be used to develop an evidence base and that evidence base will then be tested by a health technology assessment body—predominantly, we think, the Medical Services Advisory Committee—to demonstrate for the taxpayer, for the parliament, for the government and for consumers that we are getting value for money from those programs before they are rolled out; we are also doing the same for the existing programs.

Senator DI NATALE: I am a bit confused. Isn't that chicken and egg? How do you come up with a pod of $600 million and say, 'We're just going to take $600 million; we don't know what we're going to spend it on, but we will spend it on this thing called patient support programs that we will work on.' Surely, isn't that back to front? Shouldn't we be working out what are the programs we want to fund, and fund those, and allocate an amount, rather than just pulling $600 million—we do not know whether that is too much or not enough—and suggesting that that is a patient support program?

Ms McNeill: We have an existing $600 million for the existing programs, many of which I know you are familiar with—

Senator DI NATALE: Yes.

Ms McNeill: Such as the medication—

Senator DI NATALE: And we heard how terrible that last agreement was, so you do not want to use that as a precedent.

Ms McNeill: So we will be doing the cost-effectiveness of those, too, within the first two years of the agreement to demonstrate that they are delivering cost-effective health outcomes for consumers. Secondly, there is a $50 million allocation based on the money that has been expended on existing programs. Let us be very clear: there is a lot of feedback from stakeholders who actually benefit from those programs and would like to see them continue.

Senator DI NATALE: Absolutely.

Ms McNeill: What we have done is put the expected money aside, based on what we have used under the Fifth Community Pharmacy Agreement if you expand and introduce new programs. We have put that amount of money aside to be able to invest in those programs,

should they be able to demonstrate their cost-effectiveness and value to consumers and to government.

Senator DI NATALE: What happens if you—

CHAIR: This is your last question.

Senator DI NATALE: It is just on the same point. What happens if you do not have a strong enough evidence base to fund $600 million worth of programs?

Mr Bowles: We will not spend it on items that are not cost-effective or effective or whatever.

Senator DI NATALE: Again, this is a basic question that I am not sure of the answer to: are you obliged to spend the headline figure in the community pharmacy agreement?

Mr Bowles: We have the money there to spend. We are talking about a five-year period here. We want to trial a whole series of activities that consumers and others are very, very interested in. We are going to do that and then implement that over the life of the agreement.

Ms McNeill: To answer the second part of your question, the Sixth Community Pharmacy Agreement clearly allows for an annual reconciliation of the money—again, listening to the feedback from the ANAO—on the volumes of scripts that were actually dispensed over the annual year of the agreement so that we can reconcile the money that is being expended. We will be reporting annually to the government, to the minister, on the expenditure on the individual programs so that the minister can continue to make an annual decision on how those moneys are expended and invested—again, listening to the feedback from the ANAO.

Senator REYNOLDS: Good morning, Secretary and Minister. I also have some questions on the Sixth Community Pharmacy Agreement. In relation to the discussions we have had this morning in response to Senate Di Natale, I want to clarify something with you. In relation to the question, 'Why are GPs treated differently from pharmacists?', if I have understood your answer correctly, it is because it is under two completely different systems. So the way the PBS is operated is very different from the MBS. Ms McNeill, you have said that under the PBS you have negotiated the maximum rates that pharmacists can charge, whereas the MBS is setting the lowest rate. So doctors then have the opportunity to charge more, as many of them do. Did I get that right?

Ms McNeill: That is correct.

Senator REYNOLDS: So it is like comparing apples and oranges in a way, in my understanding.

Mr Bowles: Yes.

Senator REYNOLDS: Ms McNeill, you started to talk about the new AHI. Can you give us more information about how it has come about and the reasons it has come about.

Ms McNeill: Certainly. One of the issues that we encountered in the negotiations for the Sixth Community Pharmacy Agreement was that, unlike other parts of the health sector, we had not only failed to maintain the status quo for remuneration for pharmacies but we also actually had a drop in remuneration of 16 per cent in the average script price over the life of the Fifth Community Pharmacy Agreement. A lot of that had to do with the fact that not only do pharmacies have trading terms which we do not consider a remuneration—and that is not of interest in this space—but also that we do actually set the dispensing fee linked to the price

of the medicine and that, with the efficiencies that price disclosure was generating to the PBS, which are really good outcomes, it was actually disproportionately affecting dispensing fees. So what we have done is delink the remuneration for the dispensing of a medicine from the price of the medicine, which again was something that the ANAO picked up on in the evaluation of the Fifth Community Pharmacy Agreement. In doing so, we have restored remuneration to the average dispensing fee over the life of the Fifth Community Pharmacy Agreement but with indexation over those five years as well.

Senator REYNOLDS: That is a transaction-based approach so that the pharmacists get an agreed rate per whatever they dispense?

Ms McNeill: Yes.

Senator REYNOLDS: Rather than based on price disclosure?

Ms McNeill: That is correct. Because, under the Fifth Community Pharmacy Agreement, a proportion of the dispensing fee was linked to the price of the medicine, it was affecting the dispensing fee for the medicine. There is also the fact that, when you are holding an expensive medicine, there is obviously a higher cost associated with that with respect to capital, and that is acknowledged in some of the higher fees under the AHI. We were finding that pharmacies were not being fairly remunerated in view of the fact that, whether you handed over a medicine that was worth $10 or handed over a medicine worth $15, the value of the service and the cost of delivering that service were being disproportionately affected by linking it to the price of the medicine.

Senator REYNOLDS: That arrangement was done under the fifth agreement. So presumably then, in the fifth agreement, there was no capacity, as price disclosure kicked in, to compensate pharmacists for that? So there is no mechanism within that fifth agreement to do that?

Ms McNeill: That is correct.

Senator REYNOLDS: As price disclosure kicked in, which clearly has been a very good thing for the taxpayer—correct?

Ms McNeill: Correct.

Senator REYNOLDS: It is making some medicines cheaper, which is giving us more money for new medications and more expensive ones?

Ms McNeill: Yes.

Senator REYNOLDS: When you said there was a 16 per cent impact, was that getting worse? Did it start off less and compound as price disclosure kicked in?

Ms McNeill: Did it start off less? No. The indexation in the first year of the fifth agreement was frozen. So it did have a negative drop just on the dispensing fee itself. But then, as price disclosure kicked in, particularly from 2012, when expanded and accelerated price disclosure was applied to over 50 per cent of medicines on the F2 formulae, that was when we started to see the marked change.

Senator REYNOLDS: There have been some concerns that AHI will drive up costs for consumers; that has obviously been some of the public speculation. I wonder whether you could address that a bit further and tell me what component of the total cost will the AHI be for consumers.

Ms McNeill: Certainly. There are claims out in the media that there is a 23 per cent growth in pharmacy remuneration due to the AHI, the handling fee. That is actually not the case. It is actually related to the increased script volumes under the Sixth Community Pharmacy Agreement. Just to contextualise that, whilst there is a 23 per cent growth in the value of the Sixth Community Pharmacy Agreement over the Fifth Community Pharmacy Agreement, the Fourth Community Pharmacy Agreement to the Fifth Community Pharmacy Agreement was a 35 per cent increase in the value of that agreement, again largely driven by script volumes. So it is not uncommon and it is predominantly script driven in the cost of the system. I think it is important to recognise that, with the AHI, that is a cost that is being borne by the government rather than the consumer. So where a medicine—

Senator DI NATALE: The government—

Senator REYNOLDS: Excuse me, I would like Ms McNeill to finish her answer.

Senator DI NATALE: I am sorry.

CHAIR: Senator Di Natale, you have had a fair go.

Senator DI NATALE: Where does the government's money come from?

Senator REYNOLDS: I would like to actually hear the answer to my question first.

CHAIR: Senator Reynolds was asking questions and you then interrupted, Senator Di Natale.

Ms McNeill: The concerns that have been raised in the media are about the AHI impacting on the consumer. With the way that the process is structured, around 50 per cent of medicines will cost more under this arrangement and around 50 per cent will cost less. In particular those medicines that are currently valued at $23.90 will see some increase in their cost to the government, whereas those that are over $23.90 will actually reduce in cost to the government. The point that I make about the consumers is that, where a medicine is attracting a PBS subsidy, the consumer therefore is paying no different price in respect of the co-payment that they make. Some of the concerns that have been raised in the media are about those medicines that are under the general co-payment and the private market for that area. It is not going to change the price because there is a handling fee. That does not increase the price of the private market; this is the market with respect to which the government pays.

I also think it is important to recognise in this space that that is a very heavily competitive market with significant discounting going on in the sector. For example, with amoxicillin, if you charge the maximum price to a general patient, that could be as high as $12.90, but we see it being charged at around $5.90. Introducing AHI to the cost of these medicines is not going to impact on the discounting going on in the market.

Senator REYNOLDS: Thank you. That is somewhat complicated.

Ms McNeill: I am sorry, there is no simple answer to that one.

Senator REYNOLDS: If you were explaining this to a consumer out there who has been reading that they are going to have to pay a 23 per cent—I think you said—extra cost, say, in getting their amoxicillin or some other medication, what would be the answer for them? Will they be more out of pocket?

Ms McNeill: No. If you, for example, are a concession-patient mum with three children and you get your medicines for $6.10—let us put aside the discounting for co-payment

arrangements coming into the parliament at the moment—you are still going to pay $6.10. There is no change to the price that you pay for your medicine. If you are a general consumer and you are having emergency—

Senator REYNOLDS: Is this non-concessional?

Ms McNeill: Yes, non-concessional who is paying the $37.70 a medicine, you are still going to be paying the maximum of $37.70 a medicine. If you are a general patient, a non-concessional payment, and you access your scripts under the general co-payment, because it is subject to market competition, you are not going to see a change in the price of your medicine.

Senator REYNOLDS: So the bottom line for consumers, concessional and non-concessional, with all of these complicated payment arrangements, some more expensive and some less, is that you will not be paying any more when you go to the pharmacy for your scripts?

Ms McNeill: That is correct.

Senator REYNOLDS: Everything else is sort of behind the scenes and the government picks up the variations?

Ms McNeill: That is correct.

Senator REYNOLDS: You mentioned briefly in response to Senator Di Natale an annual reconciliation process; I have not heard of that before. Can you tell us a little about what that process is and why it has come about?

Ms McNeill: Certainly. This is again taking on feedback from the Australian National Audit Office's review of the Fifth Community Pharmacy Agreement with something that we have done in consultation with the guild and other stakeholders and their feedback. What we will be doing is looking at the expected volumes of medicines dispensed, both subsidised and non-subsidised—those under the general co-payment—to ascertain that what we are expecting to see as remuneration going out to pharmacies and to wholesalers and the expenditure that government is expecting to incur is going as anticipated. We will report back annually to the government via the minister on those reconciliations.

Second of all, we will also be looking at the expenditure with respect to the programs, both the existing $600 million and the potential additional $50 million and the additional $600 million thereafter, and reporting back to the minister annually not only on the expenditure that has been undertaken with respect to those programs but also the proposed investment in the following financial year so that the minister and the government can make a decision on where those funds should be going.

Senator REYNOLDS: That is very encouraging. In relation to the concerns that Senator Di Natale raised—this might be one for you, Secretary—in proximity to the ANAO report and the negotiations, clearly something the department has taken out of its engagement with ANAO is that there obviously were not sufficient mechanisms in the fifth agreement to do what I would call your compliance auditing every year to make sure that we are getting value for money and what we are supposed to be delivering is being delivered. Then you have the flexibility to keep transforming the program to keep up to date with your priorities and best practice.

Mr Bowles: That is a fair summary. I think we have learned from the recommendations of the ANAO report into the fifth agreement and we have tried to actually build the outcomes of those recommendations, if you like, into whatever we do across the broad range of issues that we are dealing with in the sixth pharmacy agreement.

Senator REYNOLDS: Clearly not enough flexibility was built into the fifth five-year agreement. As things like price disclosure started to impact, there was not the ability to make changes to make sure that pharmacists were not—

Mr Bowles: No. I suppose that it is like any five-year agreement. If you strike a deal for five years, it stays in for five years. I suppose the only thing that really changes during that time is script levels.

Senator REYNOLDS: Or changes to policy and contractual arrangement—say, the price disclosure—so you have to have some flexibility—

Mr Bowles: Yes, things like that.

Senator REYNOLDS: And good practice?

Mr Bowles: Yes.

Senator REYNOLDS: Is that what the ANAO said? Good practice is to make sure that you have flexibility to audit and ensure compliance but then adjust as times and circumstances change.

Mr Bowles: That is right.

Ms McNeill: One of the reasons for the guild also being amenable to doing this is that the guild's original ask under the Sixth Community Pharmacy Agreement was for an investment of over $21 billion. Of course, through the negotiation process, we have actually reduced that quite considerably. So it is in everybody's interests to ensure that actually the money that government has decided to invest is being expended as anticipated and to give them the reassurance and the confidence that we are actually monitoring that as well.

Senator REYNOLDS: My final question for the moment is: do medicines in the F2 formally rise under this agreement? I had some suggestion that F2 categories—

Ms McNeill: I am sorry to get a little technical, but we talk about it in two different ways: ex-manufacture, which is the price for which the manufacturer sells the drug to the Commonwealth; and then when you add on the dispense price maximum quantity—we do not think of simple names in this sector—for when you dispense the medicine. For the ex-manufacturer price, no, that will not increase. The fact that the government is willing to pay the handling fee means that there are some medicines that, when you add on the percentages, will now be more expensive to the Commonwealth, and that is what I talked about earlier.

Senator REYNOLDS: The 50 rise and the 50 drop.

Ms McNeill: Yes. With medicines under $23.90 at an ex-manufacturer price, we will see some increase in their cost to the government.

Senator REYNOLDS: So that was the linkage between—

Ms McNeill: Yes. But everything over $23.90 will now be cheaper to dispense, for the Commonwealth.

Senator REYNOLDS: Thank you, Chair.

CHAIR: I will leave it open so that you can finish later.

Senator McLUCAS: That is where I want to go to. With the shift from the six different price points to the flat fee of pricing for the handling of the medicine, what is the relevance of the $23.90 figure?

Ms McNeill: The relevance of that is that people have been asking us, 'Will the medicines cost more or cost less?'

Senator McLUCAS: What is that?

Ms McNeill: If a medicine costs $23.90, it will now potentially cost more to the Commonwealth because of the AHI.

Senator DI NATALE: It will cost more, did you say?

Ms McNeill: Yes. If a medicine costs $23.90, it will potentially cost more now to the Commonwealth because of the AHI. However, any medicine that is priced over $23.90 will now be cheaper to the Commonwealth, and that was—

Senator McLUCAS: I will not unpack that now. That is the tipping point.

Ms McNeill: Yes.

Senator McLUCAS: If it costs under $23.90, what of the old six levels does that capture?

Mr Bowles: That will be different.

Ms McNeill: It is a different structural basis.

Senator McLUCAS: I will ask the question differently then. What drugs are captured in that under $23.90?

Ms McNeill: There are a broad range of drugs at $23.90 to the government that are captured in that space and then there will be a broad range of drugs that are covered over $23.90. We are talking about 5,200 brands of medicines.

Senator McLUCAS: I know. Let us go to the top 10. Of the top 10, which ones are in that under $23.90?

Ms McNeill: Just one moment.

Senator McLUCAS: I have a list here.

Senator Nash: Can I ask the senator to clarify? When you say 'top 10', do you mean the most commonly dispensed?

Senator McLUCAS: Top 10 prescribed in Australia.

Ms McNeill: Some of the drugs that you would potentially—

Senator McLUCAS: You do not have the list?

Ms McNeill: I do not have the list with me, no.

Senator McLUCAS: I have a list; let us go through my list.

Ms McNeill: Sure.

Senator McLUCAS: I cannot pronounce them very well, but atorvastatin is one.

Ms McNeill: Only low dose atorvastatin would be under $23.90 and high dose of atorvastatin would be over $23.90; therefore, it is a bit of a quid pro quo.

Senator McLUCAS: As the highest prescribed drug, I have atorvastatin, with over eight million prescriptions.

Ms McNeill: That is correct. But atorvastatin comes in a number of strengths, so it depends on what strength you use as to whether a drug will be under $23.90.

Senator McLUCAS: Can you disaggregate that number of prescriptions for me?

Ms McNeill: Not off the top of my head, but I will take it on notice.

Senator McLUCAS: Thank you. What about rosuvas—

Ms McNeill: Rosuvastatin.

Senator McLUCAS: Thank you. Seven million prescriptions?

Ms McNeill: That is correct.

Senator McLUCAS: Is that under $23.90?

Ms McNeill: Again it depends on the dosage. If you have a low dose, it will be under $23.90; if you have a high dose, it will be above $23.90.

Senator McLUCAS: What is the rule of thumb split? I am trying to get an understanding of what drugs we are talking about and then who will pay for that increased cost.

Ms McNeill: The government will pay for that increased cost.

Senator McLUCAS: What if you are a general patient?

Ms McNeill: Even if you are a general patient. At the moment, if a drug is under $23.90, the price will go up; and, if it is over $23.90, the price will go down. So there is a potential that some general patients may benefit because some of the drugs that are near the $37.70 currently may actually go under the general co-payment as against going above the general co-payment because of the $23 threshold point. But what you are asking, I think, is about the general co-patients who have under co-patient scripts. We are saying that is not expected to impact the price of those medicines because it is a private market.

Senator McLUCAS: So there is potentially a cost to the general consumer?

Ms McNeill: No, I do not accept the premise of that.

Senator McLUCAS: The assertion that I have here, in an article published on 28 May, is that, for amoxicillin, the new fee will drive up the low-cost drugs from $8.29 per script to $11.75 per script. General consumers will pay for the extra out of their own pocket, but when a pensioner buys them the taxpayer will pick up that extra tab.

Ms McNeill: With amoxicillin, the taxpayer will pick up the change in price; that is absolutely correct. When you talk about the current price of amoxicillin and the $8.29, the average price that it is actually being dispensed for is between $5.90 and $6.10.

Senator McLUCAS: That is not the question.

Ms McNeill: My point is that there is an assumption that is being made there that, if you introduce an AHI, the handling fee, that is automatically passed on in a private market for competitive pricing of drugs; and our experience is that that is not the case.

Senator McLUCAS: Let us go to that experience. What is the data around that?

Ms McNeill: What is the data around?

Senator McLUCAS: The experience that you describe as not being passed on to consumers.

Ms McNeill: In the extrapolated data that we purchase, we see the average pricing of the medicines coming through, based on the volumes and the dosage relativity, and we are seeing that the prices that medicines are being sold at are considerably lower than the maximum price that existed on the PBS. At the moment we only have selected data in that space; we do not have full access to every under co-pay script dispensed. As part of the Sixth Community Pharmacy Agreement, we are getting access to all of that data, so that we can actually verify.

Senator McLUCAS: That data is the cost of the medicine to a consumer at point of sale?

Ms McNeill: That is correct.

Senator McLUCAS: For all medicine?

Ms McNeill: That is correct. Under the Fifth Community Pharmacy Agreement, we started collecting under co-pay data, which was script volumes, but we did not have access to the actual price at which that medicine was being sold. As part of the negotiations, we have secured the fact that we will now get the pricing data for that as well, so the parliament and the government will have full view of the actual prices that are being charged. That is also important and it feeds into what we have not discussed as yet; that is, as part of all of these processes for the changes in remuneration, one of the things that the Sixth Community Pharmacy Agreement provides for is an independent review within the first two years of the agreement to assess the remuneration and the regulations, including location rules, under the community pharmacy agreement. The cost effectiveness of remuneration has not actually been assessed since 1989—again, something that we learned from the ANAO regarding the need to assess this basis.

Senator McLUCAS: You are saying that there will be no increase at all in the price of medicines to people who have a health care card; I accept that.

Ms McNeill: Yes, that is correct.

Senator McLUCAS: There will be an increased cost to the taxpayer—

Ms McNeill: Yes.

Senator McLUCAS: but that is another question.

Ms McNeill: But, as I have said, some will be cheaper—

Senator McLUCAS: As for general patients who do not have a health care card, are you saying that there will be no increase in cost at all?

Ms McNeill: We are saying that, with the medicines, for some general patients who are currently paying the co-payment, the $37.70, because some of the medicines that were around that space will become slightly cheaper, we expect them to fall and to be cheaper for those consumers. Also, with respect to the private market, we do not anticipate seeing any change in the prices charged in the competitive discounted market.

Senator DI NATALE: Obviously this is a contested area because some people would argue that prices will go up. If you are in a country town and you are the only pharmacist, what competition is there?

Ms McNeill: I am sorry; I do not understand what you are asking for.

Senator DI NATALE: You are saying that it all relies on competition. But if you are in a country town—and there are a lot of regional areas where there is only one pharmacist—where is the competition?

Ms McNeill: It is up to the consumer and the pharmacist as to what the charge is.

Senator DI NATALE: No, I am sorry. The premise of your argument is that prices will not go up because there is competition; this is a competitive market. In many regional towns across Australia, there is one pharmacist. How is competition going to keep prices down in those areas?

Ms McNeill: That is a matter for the individual pharmacist and the consumer.

Senator DI NATALE: No. You have said that this is a competitive marketplace and you have used that as a justification for your argument that prices will not increase.

Ms McNeill: But you are assuming that the rural pharmacist who is a single-service provider does not discount their under co-pay medicines already.

Senator McLUCAS: You are asserting differently. I want to get to some data, if I can.

Ms McNeill: I think that is the important thing. I appreciate that there are multiple opinions on this at the moment. We see certain extracts of data and we have a different perspective being presented here. The important thing to acknowledge is that, under the Sixth Community Pharmacy Agreement, we are going to get that data and then we can have a conversation about whether what we had anticipated and what we were seeing from extracts of data is translating under the agreement or whether there are other areas that we need to be concerned about. Importantly, we are having an independent review of remuneration within the first two years of the agreement to assess that.

Senator McLUCAS: Let us go back to the policy. How can you assert that no consumer will pay any more?

Ms McNeill: We have said that we do not expect a consumer to pay any more.

Senator McLUCAS: How can you say that? How can you confirm to me that we do not expect people will pay any more?

Ms McNeill: Because we see the discounting and the cheaper prices of the medicines not only in the major centres but in some of the rural towns. I cannot give you an absolute, in the 5,400 pharmacies, as to what will happen exactly in every circumstance. We see, as a trend, the medicines being discounted for patients who are under the general co-payment. I am also telling you that, for the first time, we are actually going to get all of that data—

Senator McLUCAS: Yes, I get that.

Ms McNeill: so that, in two years time, when we are having this conversation, we will have the clear information in front of us.

Senator McLUCAS: What is the data that you can point me to?

Mr Stuart: There are two other effects that are occurring at the same time.

Senator McLUCAS: Can I just pursue this, Mr Stuart?

CHAIR: Hang on, Senator McLucas.

Senator McLUCAS: Come on; we are just trying to get—

CHAIR: No; hang on. My job is not to protect witnesses; it is to keep order. If Mr Stuart wants to add something to the answer, he is entitled to do so. There has been a lot of interjecting on that side and I have let some of it go. But if Mr Stuart wants to add something, he can do so and then you can ask another question.

Mr Stuart: I was going to point out that there are two other things going on at the same time, to the benefit of consumers. One is the general continuing fall in medicine prices in the F2 formulary as a result of ongoing price disclosure. The second is the capacity for pharmacists, if they wish, to discount the co-pay for patients by a dollar. Both of these are operating at the same time. I go back to Ms McNeill's statement that it will be very interesting, in the data that we will now have over the life of the sixth agreement, to see how that all works out for the consumer.

Senator McLUCAS: I accept that. But Ms McNeill was saying—I forget the language—that she does not expect there to be any increases for consumers. I am not confident enough with that sentence to say that there will be no increase, and I am trying to understand where the potential is for increased costs to consumers. Is it regional and rural? Is it people who are on certain prescriptions that are currently the low-cost prescriptions that will have an increase in the cost of handling? I need more information that drives your ability to say that you do not think there will be any increase in cost.

Ms McNeill: Certainly. We also had, under the Fifth Community Pharmacy Agreement, an increase in dispensing fees. Although we have said there has been an average drop—the percentage relationships—we have actually seen with medicine prices the dispensing fee actually increase over that period of time too, and that has not been passed on to consumers either. So, as Mr Stuart said, price disclosure has been an incredibly effective mechanism for making medicines cheaper for the general patients, and that will continue. We still have around 40 per cent of the F2 formulary discounting; and every time those prices reduce it is general patients predominantly that benefit from that. What we are continuing to see is that those prices will drop and, as those prices drop, the medicine itself becomes cheaper. Also, through price disclosure and the way that we see discounting translating for people, it is the ex-manufacturer price of the medicine that is determining whether or not a discount will be offered or a lower discount will be offered, not the dispensing fees that are placed on top of the cost of the medicine. But, as I have said, we are collecting the data so that we can actually verify that for you under the Sixth Community Pharmacy Agreement.

Senator McLUCAS: Under the fifth agreement, you were collecting data on certain drugs, including at point of sale?

Ms McNeill: No. The Fifth Community Pharmacy Agreement was the first time that we managed to access full under co-payment data, but with the specific exclusion of the price that the medicine was sold for. So I could tell you about volumes and where they were coming from, but I could not tell you the price. What we have negotiated under this Sixth Community Pharmacy Agreement is full access to that information. That is not only the discounted price that someone is selling an under general co-patient script for but, should a pharmacist offer the discounting of the co-payment to a patient, that would also be captured so that we can see the impact of that measure too.

Senator McLUCAS: Going back to the data that was collected under the fifth agreement, that does not tell you what it was sold for; you have confirmed that.

Ms McNeill: Not the whole of life, no.

Senator McLUCAS: The discounting trend: how do you know that?

Ms McNeill: How do we know?

Senator McLUCAS: How does the department know about the level of competition resulting in discounted drugs?

Ms McNeill: There are two ways to do that. I think we all get online and look at some of the discounting that is available through the various pharmacies around the country.

Senator McLUCAS: You might, Ms McNeill; I have better things to do.

Ms McNeill: We also know what kinds of prices are being offered. Even if you are not shopping online for your script, there is the fact that people are searching for that, so we can see how those prices change over time. Also, the IMS collect data with respect to the data sales of medicines and the dispensing of those medicines. We do at times get extracts of that so that we can analyse and determine what is going on in the market, to calibrate at times what we are seeing happening with price disclosure.

Senator McLUCAS: Is there a report that you can point us to that captures that information, or is that all done internally?

Ms McNeill: No. Whilst we publish all of the script volumes annually for the parliament, as was agreed with the passage of that legislation, the extracts that we have been receiving, which we have been purchasing from a third-party provider, are not in the public domain. One of the reasons that we have ensured that this data is provided, as part of the dispensing of a script under the Sixth Community Pharmacy Agreement, is so that that data can be made available for the public.

Senator McLUCAS: Can you confirm that nine of the 10 most prescribed drugs—and we were going to that earlier and I am coming back to it—are potentially in scope to be more expensive to patients, given the conversation that we have had? I am talking about general patients. I accept your point about dosage levels, but let us put that aside.

Ms McNeill: I accept that they are currently priced under $23.90.

Senator McLUCAS: Nine out of the 10 are in the high-volume, low-cost group that sits under $23.90 and potentially could cost more.

Ms McNeill: Some of the forms and strengths of those drugs—I appreciate that you have put that as a caveat and I will reiterate that—are currently priced under $23.90, yes.

Senator McLUCAS: Have you done any modelling on patient types? So people with certain chronic diseases that may have a large number of scripts that they are filling to manage their illness—have you done any modelling on that?

Ms McNeill: No.

Senator McLUCAS: Why not? Because you absolutely believe there is going to be no cost increase to patients.

Ms McNeill: I am not sure why I would be modelling.

Senator McLUCAS: Someone with chronic heart problems who will—now I am making it up because I am not a doctor—

Mr Stuart: I might make a comment and then I want to briefly go back to a thing we were discussing yesterday. Where the forms and strengths are stronger—that is, for more chronically ill patients—they are more likely to be above the $23.90. It is the lower forms that are under $23.90.

Senator DI NATALE: Can you repeat that? I missed that.

Ms McNeill: When you have chronic disease, you tend to be using the higher dosage forms of the medicine.

Senator DI NATALE: I am not sure that is actually accurate.

Mr Stuart: I do not want to take that comment too far, but if you are on the higher strengths they are more likely to be above the $23.90. The issue about modelling is that in order to model something like this you have to make certain assumptions about the behaviour of the pharmacists and the patients. It is those assumptions we have been talking about. The assumptions you make then lead to the outcomes of the model. That is the problem.

Senator McLUCAS: Not necessarily, Mr Stuart. There is a classic profile of a person with a certain type of diagnosis that you would expect would take these drugs. Doctors do follow the rules.

Mr Stuart: It is not something the department has done.

Ms McNeill: Eighty per cent of the scripts that are being used on the PBS are for concessional patients. If you ask what modelling we have done with respect to concessional patients, we have focused on the potential for the discounting of the co-payment to make those medicines cheaper for those consumers—those people who have co-morbidities who are protected by safety nets. Those are the people we have looked at with respect to modelling.

Senator McLUCAS: I might come back to this issue about the handling fee. Given the time, I will now move quickly through the discounting by a dollar issue. Can you explain to us the changes that allow pharmacists to discount scripts by $1?

Ms McNeill: Legislation is currently before the parliament to provide the pharmacist the option—it is not mandatory—of providing a discount of up to $1 of the PBS concessional or PBS general co-payment made by a consumer.

Senator McLUCAS: What has the guild said about the take-up of this opportunity to discount?

Ms McNeill: With respect to what, Senator?

Senator McLUCAS: Are they going to adopt it? I understand there has been some public discussion from the guild about their position on this.

Ms McNeill: I believe they have issued a statement in the last few days saying that they support all the measures and that the discounting of the co-pay is a matter for the government.

Senator McLUCAS: What does that mean in your understanding of reading that press release?

Ms McNeill: I think the important thing for me is that it is government policy to introduce discounting of the co-payment for concessional and general patients. That legislation is currently before the parliament.

Senator McLUCAS: My reading of it is that they are not that enamoured with the $1 opportunity to discount.

Mr Bowles: I do not think we can talk for 5,500 pharmacies out there and what their behaviour might be, if pushed.

Senator McLUCAS: What savings does that result in?

Ms McNeill: To the Commonwealth?

Senator McLUCAS: Yes.

Ms McNeill: It is anticipated to deliver $366 million over five years.

Senator McLUCAS: How is that a saving to the Commonwealth? Explain that for us.

Ms McNeill: The saving is because if a patient is benefiting from the discounting of a co-payment by up to $1 it will take that patient longer to reach their safety net. I would like to put on the record that that does not mean they pay more for their medicines. They still pay the same amount of money to reach their safety net. It is just that because of the competitive pricing they are getting more of their medicines up-front before they hit the safety net.

Senator McLUCAS: Have you done any work on working out much longer it will take concessional patients to hit the safety net?

Ms McNeill: Concessional patients have quite a variability in the number of scripts that they use to reach their safety net. There are a cohort of people that use 62 scripts a year. So they get two for free. Then there are high users who tend to hit the safety net within five or six months of the year. It is quite a broad spectrum. I guess the way to look at it is that if you are getting a dollar discount on every script that you get because you go to a competitive pharmacy who offers the full dollar, that will be saving you $60 in the lead-up to that. So that would be an extra 10 scripts before you hit the safety net. But, again, I really need to put on the record you are not paying any more for your medicines; it is just taking you longer to reach the safety net because you are getting the discounting up-front.

Senator McLUCAS: Well, if you are taking longer to get to your safety net you are—

Ms McNeill: It takes you longer to get to your safety net, but not financially. That is a very important point that we need to put on the record, which is that if you get your scripts at the $6.10, you are protected by the $366. If you get your scripts for $5.10, you are still protected by the $366. What it means is that if your pharmacist is discounting then if you are the person that you are referring to with co-morbidity and multiple scripts per month, that might be saving you $5 or $6 a month that you choose how to use then, as opposed to the person that decides that the safety net is important to them and wants to pay the full price and wants to get their medicines for free after the safety net.

I want to also put on the record that the majority of concessional patients do not hit the safety net. Eighty per cent of patients on a concessional do not. So the average person over 65 who is on a concessional status is going to be getting $40 in their pocket back each year if they use a pharmacist that is discounting the co-payment.

Senator McLUCAS: If they can find one.

Ms McNeill: That is money straight back to them, Senator.

Senator McLUCAS: Can I go to the National Diabetes Services Scheme. It is slightly different than the agreement, although it is related; it is part of the agreement. Where are you in negotiation with Diabetes Australia at this point in time? Is that completed?

Ms McNeill: The current NDSS does not expire until 30 June 2016. Negotiations will start in the next financial year.

Senator McLUCAS: Does the government intend to maintain the current funding levels to Diabetes Australia to deliver the current range of diabetes and information services, along with the aids and equipment? Tell me about the aids and equipment program. Where is that going?

Ms McNeill: At the end of the current agreement, so 30 June 2016, the supply and delivery of the consumables will move to the wholesaling arrangements under the CSO arrangements under pharmacy. The decision that we have taken on that reflects the considerable cost efficiencies that can be delivered.

This was an issue that was first raised with Diabetes Australia in the lead-up to the negotiations for the current agreement, so in the 2010-11 financial year. We are finding that it costs us—for example, blood glucose test strips through the NDSS—$5.11 to deliver that box to a consumer. If those blood glucose test strips are delivered through the PBS, which they are also available on, it will cost us 70c to actually deliver that product.

Senator McLUCAS: I do not want to prosecute whether or not moving it is an issue—

Ms McNeill: No. We are actually moving that across. What continues to be part of the NDSS is obviously the programs and services that support patients, registrant services, education and support. One of the things that was disappointing in the last agreement—and we have been working very hard on it under this agreement—was that a lot of those programs and education services were only coming out in the last years of the agreement. We want to try and ensure that those high value-add programs are an area that Diabetes Australia can focus on.

Senator McLUCAS: Have you negotiated with Diabetes Australia a price for those education programs?

Ms McNeill: The current agreement is still underway. They still have a suite of programs and deliverables that they are yet to provide and have to do so under the final year. As we go into all negotiations we will look at the value of the services and the additional services that government may wish to look at. I think it is important to look at this issue in respect of the National Diabetes Strategy. The government just finished their consultation on this over the weekend; it was out for public consultation. Obviously the outcomes that come out of that process, any policy or program areas, we will give consideration to as well as we negotiate the NDSS. We see it as a seamless issue about supporting people with diabetes.

Senator McLUCAS: So there is no agreement at this point in time that around $40 million will be the funding for the education programs?

Ms McNeill: No, Senator. What we do in every five-year agreement is sit there, look at it and say, 'What are the services? What are the programs? What did the evaluations of the different programs identify? What are the new areas of need or focus?' Like I said, we are very mindful at the moment that there is the National Diabetes Strategy being worked upon

and that that may be a significant feeder into what may or may need to be negotiated in a future NDSS agreement.

Senator McLUCAS: A final question around diabetes: does the redirection of product supply funding to the six CPA include insulin pump consumables?

Ms McNeill: That is correct.

Senator McLUCAS: It does. Why are the two agreements not in tandem?

Ms McNeill: Why are they a year apart?

Mr Stuart: History.

Senator McLUCAS: History. Are you intending to bring them into line?

Ms McNeill: The next agreement is certainly an opportunity to do that. Everybody likes the certainty of their five years in the way the agreements have been done. The opportunity now presents itself because we are moving the products and services around. That was a separate negotiation that Diabetes Australia had to have with their wholesalers and their manufacturer suppliers. So it is an opportunity. We will give consideration to that, but only in full consultation with the relevant parties.

Senator McLUCAS: I have one other issue that I want to have a conversation about.

ACTING CHAIR (Senator Siewert): Does anybody else have anything else on this particular item?

Senator DI NATALE: I have a few on diabetes and a couple of others. Are you moving on from the agreement?

Senator McLUCAS: Yes.

Senator REYNOLDS: Let's do the questions on diabetes.

Senator DI NATALE: That is part of the agreement, I suppose. I have got a couple, but Jan has probably covered the diabetes questions. I am more interested in a few of the other things that we were discussing, the $1 discount. Can I just ask you quickly about the $1 discount? Just to be clear about it: that is optional for pharmacists?

Ms McNeill: Correct.

Senator DI NATALE: Again, you are relying on the fact that there will be competition to ensure that that gets passed on?

Ms McNeill: Yes.

Senator DI NATALE: That is the basis. Going back to my original question: if you are in a regional or rural area and there is no competition are you still confident that the dollar will be passed on? That is a dollar that a pharmacist does not get in their pocket.

Mr Bowles: I will make a broad comment here. I do not think anywhere we are going to assume there is a 100 per cent take-up of anything, in our thinking. That is one point. These days, with the internet and community and consumer expectation, I would not be surprised what might happen as far as discounting and all sorts of arrangements happen.

Senator DI NATALE: You are more optimistic than I am about it. As someone who lives in a regional area and pays a lot more for health care—

Mr Bowles: I have lived in a regional area.

Senator DI NATALE: You are a lot more optimistic than I am.

Mr Bowles: I lived in a regional area for 45 years before I moved here.

Senator DI NATALE: I bet you paid a lot more for most things.

Mr Bowles: Probably more for some, less for others.

Senator DI NATALE: Did you actually request the $3 discount rather than a $1 discount?

Mr Bowles: We have a range of issues that we discuss through negotiations. I am not going to go into the ins and outs of a whole range of things. A part of negotiation is negotiation and you do all sorts of things. I am not going to confirm or deny $3. Discounting the co-pay is $1.

Senator DI NATALE: Okay. I will read into that what I—

Mr Bowles: You should not read anything into that. We would look at a whole range of issues across the 20-odd items that we looked at in thinking about this arrangement.

Senator DI NATALE: Let me ask about the location rules, which is mentioned at some point. Can you just take me through the process of the review of the location rules? Who is actually conducting the review?

Ms McNeill: The details of this have not been finalised as yet. Obviously the agreement is a week old. What we have agreed is that there will be an independent review of remuneration and location rules, regulation at the one point in time because—

Senator DI NATALE: Sorry, can you just explain the remuneration bit?

Ms McNeill: So looking at the cost-effectiveness of remuneration for the dispensing and wholesaling of medicines. It is a combined review, an independent review that will be undertaken, public, transparent, in the first two years of the agreement. It will look at the remuneration. As we pointed to earlier, the ANAO noted we had not assessed cost-effectiveness of remuneration since 1989. That will be undertaken as part of that review, including looking at the wholesaler chain and how that is working for us. It will also look at the location rules and the benefits and opportunities and risks they present to the community and to consumers and to business. We are looking at those together because we did have feedback from stakeholders and consumers, who feel that location rules in some circumstances impact on competition and the remuneration of the pharmacist.

Senator DI NATALE: Have you got a sense of who will be involved in conducting the review? What sort of expertise, or who will you be recruiting?

Mr Bowles: Not at this early stage.

Senator DI NATALE: Just pharmacists, or are you going to go broader?

Ms McNeill: No, it is an independent review.

Senator DI NATALE: I have a couple of questions on the diabetes issue, but I think we have probably dealt with most of those. I am happy to move on beyond the agreement and ask a couple of questions about PBAC and the review that is going on there. That is moving beyond the agreement. I am not sure if anybody else has any questions on the agreement.

Senator McLUCAS: I want to ask some questions about cohealth in Collingwood. What was the rationale to change the approach of supporting that pharmacy?

Ms McNeill: As you know, it is the only pharmacy in the country that operates under a separate agreement. One of the main drivers for that is equity of access, which is operating under a different approach. Certainly there were some consumers who were getting their medicines cheaper but there were other consumers who, because of the subscription fee, were paying more than if they were getting their medicines through the PBS. There were also concerns raised about the fact that, to continue to get the medicines under that arrangement, they could only use that pharmacist and not go more broadly within the community, the way you or I could, to get a medicine script filled.

Senator McLUCAS: This has been going on for a very long time.

Ms McNeill: It has. There were previous ones that have also gradually been closed, and this is the last one of its kind. We have been working very closely with cohealth since the announcement to ensure that there is a smooth transition to support them in making an application under the pharmacy location rules for PBS status and looking at the fact that some of the good programs of collaborative care in a primary health network are the types of ideas that perhaps other consumers had raised and were important pilot spaces under the Sixth Community Pharmacy Agreement.

Senator McLUCAS: What is the view of cohealth about what has happened to them?

Mr Stuart: I think we shouldn't attempt to put words into their mouths.

Senator McLUCAS: Has cohealth corresponded with the department or with the minister about what happened?

Ms McNeill: They have met with both the department and the minister. We are working very constructively with them, yes.

Senator McLUCAS: But generally their view is they would prefer the previous arrangements to have applied.

Ms McNeill: That is my understanding, yes. I was not privy to the conversation.

Senator McLUCAS: What is the cost to the budget of the changed provisions?

Ms McNeill: It is $200,000 over four years.

Senator McLUCAS: I understand—and I do not have a copy of the *Hansard*—that the minister said it was not going to save the Commonwealth any money.

Ms McNeill: That is correct. This is about equity of access for people. Like I said, there are some patients there who were benefitting because the amount they were paying for their subscription was less than the total number of medicines they were using. There were other patients, particularly the family subscriptions, where it would be cheaper for them to action—

Senator DI NATALE: Prescriptions or subscriptions?

Ms McNeill: Subsidised scripts. If they were paying the concessional or general co-payment they were more likely not to have spent as much money on their medicines. Also, like I said, the issue is that they can only get that benefit if they go to one pharmacy, as opposed to the rest of us, who are used to being able to choose which pharmacy we go to get their script filled in. So it was about an equity issue for one pharmacy versus 5,400.

Senator McLUCAS: Were there complaints from health consumers?

Ms McNeill: I would have to take that on notice. That has not been drawn to my attention in this process.

Senator McLUCAS: What is the driver behind the changed approach?

Ms McNeill: As I have said, it is about equity of access in the system. There is only one pharmacy in the country that is operating this way. We are trying to ensure standardised access to the PBS for all patients.

Senator McLUCAS: But I understand they are fairly happily operating this way. There is a view from cohealth that they wanted to continue to operate this way. There is no cost to the budget whether you have the single arrangement or the PBS-type arrangement. What is the problem that had to be solved?

Mr Stuart: We have a set of laws that apply to all Australians. We had a separate arrangement here that actually disadvantaged some people.

Senator McLUCAS: And advantaged others—like many of our laws do, Mr Stuart.

Mr Bowles: At the end of the day, it is an equity issue. That is what we are addressing.

Senator McLUCAS: Was this driven from the minister or was it driven from the department?

Mr Bowles: This is an issue that came up in the agreement and we have dealt with it in the agreement.

Senator McLUCAS: It came up in the agreement? So it came from the guild?

Mr Stuart: No, it was not part of the agreement. It is a budget measure.

Mr Bowles: It came up in the context of a budget measure. It was not out of the minister's office, if that is what you are inferring. It was something else that came up in the context of the budget that was dealt with in this agreement.

Senator McLUCAS: What was the problem that we were trying to fix?

Mr Bowles: Equity.

Senator McLUCAS: From your perspective?

Mr Bowles: From our perspective, yes.

Senator McLUCAS: Cohealth has a different view about equity.

Mr Bowles: I am sure there are a lot of groups out there that are going to have different views on equity, particularly if they are advantaged by something.

Senator McLUCAS: But Ms McNeill said that she cannot recall any complaints being brought to the attention of the department from consumers. There is certainly an unhappiness from the operators of cohealth because it changed arrangements. In regard to your view of equity, Mr Bowles, I accept that there may be some winners and some losers in this, but that is pretty much the case in life for a lot of government policies. I am still unsure what the big problem was that had to be fixed.

Mr Bowles: I probably cannot add any more.

Senator McLUCAS: A different view about what equity might mean?

Mr Bowles: Yes.

Senator McLUCAS: Okay; I might leave it at that. I know Senator Brown has some questions too.

CHAIR: I will go to Senator Di Natale, then Senator Brown before we break.

Senator DI NATALE: When did the department notify the chief executive of cohealth of the change? When was she made aware of the change?

Ms McNeill: After the budget announcement.

Senator DI NATALE: So she was not given any warning prior to the announcement?

Ms McNeill: That is correct.

Senator DI NATALE: If the emphasis now is—and the AMA are on board with this, as are the pharmaceutical societies—to co-locate pharmacists within GP clinics; that is a model that we are following, isn't that what this delivers?

Ms McNeill: It is about having equal access to the PBS and accessibility and the fact that we had one differential model. Like I said, I appreciate that there were benefits and opportunities with the program. There are also disadvantages for these patients in that they have to go outside the system separately if they want to go to any other pharmacy. It was the issue of equity, that ensures all Australians have the same access to a pharmacy and the PBS. They were the reasons for doing so.

Senator DI NATALE: You cannot argue that it was a problem for the patients because the patients are unhappy about the change. The patients were very supportive of the existing model. To argue that it is a benefit to patients when they are unhappy about the change—I just do not get the problem. It does not cost any more to run it. Agreed, it was a bit of an outlier; it did not fit in with the rest of pharmacy. But the patients are happy, it does not cost more money, and it was an effective arrangement for people in a low income community—and this is a public housing area servicing very low income people. Why the need for the change?

Mr Stuart: I think we have done our best to address that question a few times already. I do not think we have anything new to say.

Senator DI NATALE: This was not a recommendation from government?

Mr Bowles: No. I have already said that.

Senator DI NATALE: I just wanted to confirm that. This was something the department decided.

Mr Bowles: It is something that came up in the context of the budget, and it has been dealt with in this context.

Senator DI NATALE: I will leave it there. We will end up going over old ground. I have a question on PBAC. The review of the PBAC submission guidelines is going on at the moment. Is that right? Is it still going on?

Ms McNeill: That is correct.

Senator DI NATALE: Could you give me an idea for the time frame for the review? Are we expecting an interim report? What are the dates for the interim reports, final reports, et cetera?

Ms McNeill: Tenders for that process only closed on 26 May—to appoint people to undertake the evaluation work. So I would have to take that on notice. It depends on the submissions we receive, the calibre of those submissions and the timings they are proposing.

Senator DI NATALE: Can you take me through the tender process? Who were you after? I thought it was an internal review.

Ms McNeill: It is being done under the Post-market Review of Authority. In order to get the best opportunity of international and domestic health technology assessment expertise we launched the tender on AusTender to seek applications. As I said, those tenders only closed on 26 May. We have not had a chance to review and evaluate those. Our expectation is that we would like it done within the next financial year so that it can be fed into and translated into PBAC processes thereafter. But I would not like to pre-empt that at the moment because we have not evaluated the applications.

Senator DI NATALE: Just to give me a flavour of who might be conducting the review, are we talking about an academic institution? I do not want you to pre-empt, but just get a sense of who might do this work.

Ms McNeill: Obviously it will be chaired by the new Chair of the PBAC, Professor Andrew Wilson. There will be a guiding group to help us assess the people that we are looking to put in place. It could be an academic institution, domestic or international. It could be a conglomeration of a number of organisations. Because they only closed on 26 May we have not started that evaluation process. I am happy to take that on notice once I have some more information to give you, if that is okay.

Senator DI NATALE: Thank you. If you could provide me with any additional information about that, that would be helpful.

Ms McNeill: Certainly.

Proceedings suspended from 10:28 to 10:46

Senator CAROL BROWN: My first question is to the minister. Are the increases in the PBS co-payment and changes to the PBS safety net announced in the 2014 budget still government policy?

Senator Nash: The minister has made some comments very clearly around this. We absolutely remain committed to the savings that are allocated to the measure. She also indicated that the crossbench did not support the increase to the PBS co-payment and to the safety net to achieve the saving, and that a replacement proposal would be announced in the near future. She has also said that the saving will not come off the table until a replacement saving is found; therefore that measure remains on the table.

Senator CAROL BROWN: Have the $1.3 billion in savings that were projected been counted as government revenue in the 2015 budget?

Senator Nash: The minister has been very clear, Senator. It is still on the table. She has also indicated that it will not be off the table until a replacement saving measure is found. That is being worked through at the moment, as I understand it.

Senator CAROL BROWN: So that is a 'yes', then?

Senator Nash: That is exactly as I have stated it, Senator.

Senator CAROL BROWN: The minister conceded that the co-payment increases and the changes to the safety net would not pass the Senate, as you have just indicated. I am trying to get an understanding of why the savings are still included in the budget.

Senator Nash: The minister has indicated that it will not pass the Senate in its current form. Again, I think the minister has been very clear. She has said that we are committed to delivering the savings allocated to that measure and that it will remain on the table until a replacement measure is found.

Senator CAROL BROWN: I do not want to labour the point but I want to get it clear. With the PBS co-payment increases and safety net changes that the minister has said they cannot get through the Senate, you are committed to the savings but not to those changes; is that what you are saying?

Senator Nash: Senator, I think the minister has been very clear. She has indicated the views, as she understands it, of the backbenchers to those measures in their current form.

Senator CAROL BROWN: Crossbenchers.

Senator Nash: Sorry, crossbenchers—in their current form. She has also been very clear to say that it remains on the table until replacement savings are found and that we are committed to delivering the savings allocated to that particular measure.

Senator CAROL BROWN: You are obviously actively looking at a different package to be put up; is that what you are saying to me? You are committed to what has been put on the table and to the savings?

Senator Nash: My understanding is that the minister has said that replacement savings would be found, so, yes, she is committed to that.

Senator CAROL BROWN: Can I ask the department: have you been asked to look at replacement savings or alternative funding savings?

Mr Bowles: As Minister Nash just said, the minister has said that she believes it will not pass the Senate, with the crossbenchers, in its current form. We will continue to look at options for the save, and, as is normal budget practice, the saves stay in the budget and on the table until we find an alternative. We will continue to look at alternatives for that particular measure.

Senator CAROL BROWN: So the department has been asked to look at likely targets?

Mr Bowles: The department is always looking at options. If one measure is having difficulty being passed in its current form, we will look at alternative forms all the time.

Senator CAROL BROWN: I am sure that is the case, but you have been asked particularly by the minister—you obviously have because she has indicated that she is looking at alternative funding cuts?

Mr Bowles: Yes.

Senator CAROL BROWN: Can the department rule out further cuts to hospital funding?

Mr Bowles: I am not sure about the cross-over.

Senator CAROL BROWN: I am trying to get an understanding of where you will be looking for these alternative savings—the $1.3 billion.

Mr Bowles: We do not have an answer to where a whole range of things would come from at this point. At the end of the day that will be a decision of government; it is not a decision of the department. We will provide advice around these issues and then they become a decision of government.

Senator CAROL BROWN: Minister, is there a timeline on when any new package might be announced by the minister?

Senator Nash: My understanding is that there is not a specific timeline, but we are hoping there will be soon. I also point out that the reason we are looking for these savings measures is because of the budget mess that the previous Labor government left us with. Perhaps I can also indicate—

Senator McLUCAS: Here we go. Always Labor's fault!

Senator Nash: Hang on; let me answer.

Senator McLUCAS: How long have you been there now?

Senator Nash: It is interesting, Senator, that you should say that. It was actually your shadow health minister that said in February this year that there were challenges in the budget and that savings needed to be found. Clearly, we are going to continue down the path of making sure we can get some economic stability back. One of the things that we are looking at is a replacement measure for this savings measure.

Senator CAROL BROWN: Thank you, Minister. I ask you: is hospital funding quarantined from these alternative funding cuts that the minister is talking about?

Senator Nash: I am not going to speculate on the minister's deliberations.

Senator CAROL BROWN: Medicare rebates—

Senator Nash: Senator, I am answering your question. I am not going to speculate on the minister's deliberations. She has quite clearly stated that she is looking for replacement savings for this particular measure, and she will be doing so in a timely manner.

Senator CAROL BROWN: Thank you, Minister. On what basis did the government choose the amounts of $5 and 80c for increasing the PBS co-payments? I will ask either the minister or the department.

Mr Bowles: That was a measure from the 2014-15 budget—last year's budget. It was a measure on the table. I do not know the basis of it; I was not here. Can we shed any light on that?

Ms McNeill: No, I would have to take it on notice.

Mr Bowles: I was not here and no, we cannot shed any light. At the end of the day, as I have said on a number of occasions, these things are ultimately a decision of government as to where they fall. It would be based on advice from the department, but the figures that were derived for the 2014-15 budget were the ones that you mentioned.

Senator CAROL BROWN: Are you saying to me that, with respect to any questions around the 2014 budget, which is relevant here because the savings measure is still in the 2015 budget, nobody can answer those?

Mr Bowles: I am saying I was not here. Ultimately, these were budget decisions in the context of 2014-15. The answer is that they were the figures that were derived for that budget, which amounted to the $1.3 billion save that you referred to.

Senator CAROL BROWN: I know they were the figures. I am asking on what basis they were arrived at.

Ms McNeill: When we have been asked these questions in the past, the percentage that we were looking at was around a 13 per cent increase for the concessional and the general patients compared to the previous one-off increases that were done in the mid-2000s, which was around the 20 to 21 per cent space. It was about identifying a number that was lower than that. I am sorry; I do not have the specific details of that with me.

Senator CAROL BROWN: Has the department done any modelling in relation to the effects of these changes to access to medicines?

Ms McNeill: Which changes are you referring to, Senator?

Senator CAROL BROWN: The changes to the amounts of $5 and 80c on the PBS co-payment.

Mr Bowles: I think I have already answered it. We are not necessarily modelling the $5 and the 80c. We will look at alternatives, as the minister said. We will look at whatever form we can over time, whether it is this quite specific measure, something slightly different or something quite different to that, to find alternatives for the save, as the minister has indicated.

Senator CAROL BROWN: I would now like to ask some questions on the proposed delisting of paracetamol from the PBS. First of all, I would like to get some background information on how many PBS scripts for paracetamol were dispensed in the last financial year.

Ms McNeill: First of all, you are making an assumption that paracetamol is absolutely going to be delisted. I know it is one that the minister has talked about quite extensively. I just want to put on the record that the final decision on which drugs will be delisted is going to the PBAC in July. In April the PBAC considered the policy principles about which over-the-counter medications they considered would be appropriate to be considered for delisting from the PBS. Those criteria were published on the department's PBS website last Wednesday. Those principles are then applied to the 352 over-the-counter items that currently exist on the PBS. We then write to the companies whose products actually fall within those criteria. Those items are then put to the July PBAC meeting, where they confirm once and for all whether, based on their criteria, the medicines that fall within that criteria should be delisted.

Aspirin and paracetamol are commonly used examples, and ones which, absolutely, under the publication of the criteria by the PBAC, are covered by that space. But I cannot confirm absolutely that that is the final decision of the PBAC in July as yet. I know you appreciate the difference with respect to PBAC recommendations.

Senator CAROL BROWN: Can you answer my question? How many PBS scripts for paracetamol were dispensed in the last financial year? I do appreciate your giving me that background information.

Ms McNeill: I will see whether my colleague has that one. Straight paracetamol should be on here: six million scripts.

Senator CAROL BROWN: What do you mean by 'straight paracetamol'? My next question is about osteo slow release.

Ms McNeill: That would be included in that. I was talking about the fact that we also have paracetamol with codeine, and anything where it is a combination item I am not counting in the six million scripts.

Senator CAROL BROWN: Of these, what percentage would have been the osteo slow release formulation?

Ms McNeill: I do not have that number with me. I would have to take that on notice.

Senator CAROL BROWN: If you could, I would appreciate that. Has the department done any modelling on the impact of the demand of other prescription medication such as Panadeine Forte and Tramadol?

Ms McNeill: When the PBAC were giving consideration to the delisting they also noticed the fact that they are currently doing a PBS authority with respect to the restrictions on medications. The authority's review has, in many instances, been about deregulating and making it easier for a general practitioner to issue a prescription. There are also particular areas with respect to drugs of dependence and antimicrobial resistance where the PBAC have come forward and said that these are areas that they may seek to actually tighten.

They are aware of the fact that if something is delisted in this space, that should be observed. But they consider that the clinical professionalism of the independent prescribers is such that they understand the usage of these drugs. They did not express a concern with that. However, they did ask that any drugs that were going to be delisted should be monitored by the drug utilisation subcommittee to ensure that there are no unintended consequences in changes in prescribing behaviour.

Senator CAROL BROWN: In the information you kindly provided, I think you told me that the department has written to companies about their views on what may be delisted; is that right?

Ms McNeill: The companies will be written to on Friday this week. I was just giving you the process in the lead-up to PBAC. We have applied the principles. We have gone through the drugs. We will write to all the individual companies affected to ascertain any comments or opinions, the way we do in normal PBAC processes. We will collect that information and present that to the PBAC in July for their final approval or recommendation of which drugs should be listed or delisted.

Senator CAROL BROWN: Are we able to have a copy of the list of companies that you are writing to?

Ms McNeill: It would be any company that has a drug. To give you the context, of the 352 items that are over-the-counter medications on the PBS, when we apply the PBAC's guiding principles we are potentially looking at 47 items to delist. It is a quite small component. It is less than 15 per cent of the over-the-counter medications on the PBS that fit the PBAC's criteria at the moment. If I am looking at 47 items, there are probably 12 or 13 companies that have medicines that are currently OTC on the PBS that would be asked to comment.

Senator CAROL BROWN: Can we have that list? It is not very extensive.

Ms McNeill: Of the potential items?

Senator CAROL BROWN: No, of the companies that you are writing to and the potential items?

Ms McNeill: Of the companies? We do not tend to put that out until the PBAC considers it, but we would be able to provide it thereafter—just because of the commercial principles in place.

Senator CAROL BROWN: The potential items?

Ms McNeill: Yes. That would, of course, be made fully public as part of the outcomes of the PBAC.

Senator CAROL BROWN: Can we have that list now?

Ms McNeill: We do not normally. We normally would give it to the PBAC first and then make it public.

Senator CAROL BROWN: Okay. So on Friday you are writing to the companies. Anywhere in this process before the decision is made will there be consultations undertaken with other stakeholders—clinicians and other stakeholder groups?

Ms McNeill: Consultations were undertaken as part of the negotiations for the PBS access and sustainability package about the benefits and opportunities with over-the-counter medications. We have had follow-up requests for information from some of those parties. We will continue those conversations with them. Obviously, once the list is put out, the idea is that when the PBAC makes those recommendations there is a five-month notification period for what it is the government's intention to delist.

Senator CAROL BROWN: In between that time there will be further consultation with other stakeholders? I was not quite clear whether you said yes or no to that question.

Ms McNeill: What I am saying is that we have already consulted with stakeholders as part of the measure to consider the delisting of some over-the-counter medications from the PBS. After that list is recommended by the PBAC, which items, we will make that publicly available and give the community four to five months notice of what those delistings will be.

Senator CAROL BROWN: Prior to a decision being made; is that what you are saying?

Ms McNeill: No. Once the PBAC makes the recommendations to the government, its advice is taken.

Senator CAROL BROWN: When was the consultation with other stakeholder groups?

Ms McNeill: That was part of the period when we were doing the negotiations on the PBS accessibility and sustainability package that the secretary referred to earlier. We met with a number of consumer and clinical groups, as well as other major stakeholders, including the self-medication industry. This issue was raised and discussed with them at that point in time.

Senator CAROL BROWN: If the date, or around when it happened, was mentioned I did not hear it.

Mr Bowles: The first meeting of this agreement started on 12 February. The specifics of going into the over-the-counter medicines happened any time from 12 February till now when the agreement was reached.

Senator CAROL BROWN: I was going to ask some questions on biosimilars, but if I am running out of time—

CHAIR: They are in this area. Proceed, Senator Brown.

Senator CAROL BROWN: Thank you. First of all, are you familiar with the report in the *PharmaDispatch* of 29 May titled 'Claims industry "misled" on biosimilars'?

Ms McNeill: I am aware of that article.

Senator CAROL BROWN: You are?

Ms McNeill: Yes.

Senator CAROL BROWN: Excellent. Given the letter of intent was signed between the industry and the government, does the level of intent include a commitment by the industry to support the changes as announced by the government in regards to biosimilars?

Ms McNeill: We have not made public the letters of intent with any of the individual stakeholders. It is only once we have got to agreement stage, and of course we have made those publicly available, that we have discussed what is within those. It is actually part of the negotiation process and we have respected the confidentiality of our stakeholders when we have gone through that process.

Senator CAROL BROWN: When the government was negotiating the issues in regard to the letter of intent, did it specifically state to industry that the government plan included changes to biosimilars that would see them being substitutable at the pharmacy level?

Ms McNeill: It was specifically raised with the industry that regarding one of the things that we had been looking at in some of the discussions was that it had been raised with us that the savings and efficiencies achieved through biosimilars under the price disclosure and statutory price reductions may not be captured in the forward estimates. I believe it was also recorded in *PharmaDispatch* that we clarified for the industry that those figures were actually included in our forward estimates.

What we did listen to the industry about was whether the expected substitution levels were appropriate. The government asked the PBAC for advice on the expected outcome for the consideration of individual biosimilar medicines by the PBAC, noting that they had considered their first biosimilar at the March PBAC for insulin glargine. On the PBAC's website it had clearly stipulated that they had taken a decision in this space and that further advice would be provided out of the April special meeting.

What the PBAC have subsequently put forward on their website is the area with respect to the burden of proof that they will consider. What they have said is that they will consider each molecule on an individual basis, but the basis of that consideration is that they would consider that a medicine is biosimilar and therefore interchangeable at the pharmacy level unless evidence is presented to suggest otherwise. So they have not said that they will allow substitution of all biosimilars. What they have made clear to the industry and to patients and consumers is that they will consider a medicine, if it is found biosimilar by the TGA, that would be potentially substitutable at the pharmacy level unless the evidence proves otherwise.

We have another biosimilar coming to the July PBAC—the medicine infliximab, which is commonly used in rheumatoid arthritis, Crohn's et cetera. This is an example of where they will apply that policy. I can neither pre-empt nor assume what it is that the PBAC will

consider. Nor do I know what evidence is before them at the moment. But what they did want to make clear is that this is the way they would approach them. Therefore, based on that, we looked at the likelihood of substitution and therefore what the impact would be on price disclosure.

Senator CAROL BROWN: I just want to go back to the P*harmaDispatch* report of 29 May. It says that the TGA is currently reviewing its biosimilars guideline, but the existing document published in July 2013 says that a biosimilar's product information should include a statement ruling out substitution. Can the department or the minister confirm whether this is still the policy, or has it changed in light of the government's commitment given its plans to save $880 million, I think it is—

Ms McNeill: $880 million.

Senator CAROL BROWN: over five years from the PBS budget measure to make them substitutable at the pharmacy level?

Ms McNeill: Before my colleague from the TGA goes into this space, I would first of all like to point out that the PBAC's advice is on the fact that when they consider a generic medicine they take it on the advice for substitutability based on the TGA having said that the medicine is safe and equivalent. When they are considering a biosimilar they will be considering it on the basis that the TGA has found the medicine to be safe and to be similar. When they did their consultations and deliberations in the April PBAC, the TGA was invited to be a part of that meeting so that the information could be shared between the two. I will now hand over to my colleague from the TGA.

Dr Studdert: As you have intimated, the TGA indicated in April that we are reviewing the guidance available to sponsors on the evaluation of biosimilars. We are going to take the opportunity to look at the whole available guidance document and make sure that the advice we provide is quite clear about what the TGA is assessing. The evidence which we work from, of course, is dictated to us by what the industry sponsor submits, and then what we will and will not make statements on accordingly.

Senator CAROL BROWN: Given that information, minister—I am not going to ask you to answer this question now—can you take on notice and confirm whether it is still the policy, or has it changed in light of the government's commitment in terms of the savings?

Senator Nash: I will do that.

Senator CAROL BROWN: I will put that question formally through, so it is clearer for you.

Senator Nash: Thanks, Senator. That would be useful.

CHAIR: Senator Brown, are you going to be much longer? You are entitled to keep going. We have obviously agreed we are going to try and stick to the time. We are a fair way over time now. Do you have much further in this area?

Senator CAROL BROWN: I will probably just do two more.

Mr Bowles: Sorry, Chair. Can we just give a perspective on your last question as well from the department's side?

Senator CAROL BROWN: Sure.

Mr Bowles: There are some important distinctions here from a policy perspective.

Ms McNeill: I just wanted to make it clear that the policy has not changed in order to derive a saving. What was changed was that the policy was clarified by the PBAC and the TGA are looking at the data and evidence and their processes in light of that as well. Based on that advice from the PBAC, we then calculated what the potential saving from that might be. It was not the saving that dictated any policy change. It is actually in the reverse. We have looked at the flow-on consequences, just as we would when PBAC considers any listing or any change to a listing and what that means, both as a cost or as a save to the Commonwealth on the PBS.

Senator CAROL BROWN: I will just ask a question of Dr Studdert. What is the accepted scientific basis or approved guidelines that the TGA will now be using to allow for biosimilars to be flagged as a substitutable, given the product information as required by the TGA states that it should include a statement ruling out substitution? Can you just give me some more information.

Dr Studdert: Just to be clear, our main role is to assess that the product in question is biosimilar. We work on a range of guidelines, largely referencing what the EU does in this space. That is consistent with the way we work across a lot of medicines evaluation, using international standards and approaches. Our key call is to, of course, assess the safety and efficacy and quality of the product, and in doing that to determine that it is a biosimilar medicine, as in similar to the referenced biological medicine product.

Ms McNeill: I should be clear that whether substitutability is allowed on the Pharmaceutical Benefits Scheme under the National Health Act is the remit of the Pharmaceutical Benefits Advisory Committee. That is why I went back to my statement earlier where we talked about the fact that where the PBAC decides whether to 'a' flag a generic medicine, it is based on the fact that the TGA found the drug to be safe and equivalent. When it comes to a biosimilar, and whether they determine that a medicine should be 'a' flagged or not, it will be because they have looked at the advice from the TGA as to whether the drug is safe and similar. What they have done in the April PBAC meeting was to clarify for the industry, to provide certainty in that space, to say, 'This is how we will be approaching biosimilars when the question of substitutability comes forward.' I want to put it very clearly on the record that they are not saying that all biosimilars will be 'a' flagged. They are saying that on the evidence presented to them they will consider them on a case-by-case basis. But based on that, they will look at the fact that it should be 'a' flagged unless the evidence presents otherwise.

Mr Bowles: I should also note the independence of the PBAC. That is not something that is influenced in any way from the department or government. They are an independent body that makes these decisions.

Senator CAROL BROWN: Has the government or the TGA done any work in regard to patient safety analysis in terms of treating biosimilars as generic and substitutional?

Dr Studdert: Let me clarify: they are not generic; this is quite a separate field of medicine and therapeutic goods.

Senator CAROL BROWN: But if they were to be substitutable at the pharmacy level, is there work being done in terms of patient safety analysis?

Dr Studdert: As my colleague Ms McNeill noted, it is largely the remit of the PBAC to determine whether they are substitutable. They will do that based on clinical data that they have available to them.

Senator CAROL BROWN: Does that include patient safety analysis?

Dr Studdert: Yes, it would, if that is what the company presented. Of course, like the TGA we work on the dossier and the material that the company present to us.

Ms McNeill: For example, when you look at some of the biosimilars we have in arthritis treatments, we now have 10 different biologics on there for treating the same condition of rheumatoid arthritis. Those drugs are found to be safe when you are swapped over—absolutely—as with a prescriber at the moment because they are a different molecule. This is not about safety. If TGA has found a drug to be safe, then the medicine is safe. PBAC will be considering whether it is suitable for substitution at the pharmacy level versus the prescriber level. We all need to be aware that the first major consideration of this is at the July PBAC meeting for the drug Infliximab, which is on the public record on the agenda. We need to watch and see what that independent clinical expert committee puts forward to the community. We cannot model something that does not yet exist.

Senator CAROL BROWN: Does any other major country treat biosimilars as substitutable at pharmacy level?

Ms McNeill: We know that Quebec is currently doing substitution at the pharmacy level. Venezuela is also doing substitution at the pharmacy level. I look to my colleagues—I think there was a third one. I will have to take the other one on notice.

Senator CAROL BROWN: The United States? The UK?

Ms McNeill: Not at this stage, no.

Senator CAROL BROWN: Any country in Europe?

Ms McNeill: Not that I am aware. I would have to take it on notice. I also put on the record that the PBAC is an independent expert clinical adviser. It has been a world leader in health technology assessment for many years, one of the first countries to introduce cost-effectiveness and clinical effectiveness assessments. They work in collaboration with a multitude of countries with respect to health technology assessment. We need to let the PBAC do its work at the July PBAC meeting and give us that advice and work out where to from there.

Senator CAROL BROWN: I suggest from your answer that we will be seeing it substitutable at the pharmacy level.

Ms McNeill: No; we need to see what they recommend. I would never pre-empt the recommendation of the PBAC. What I have on the public record is clear advice to the industry about the policy principles they will apply when they are considering a biosimilar medicine. Whether or not they make a recommendation at the July committee is something I am not privy to. We have not had the drug utilisation subcommittee, we have not had the economic subcommittee, and the committee itself has not met. I want to put on the record that we would never pre-empt a recommendation of the PBAC.

Senator CAROL BROWN: From your response then, Ms McNeill, are you saying that the decision may not be made in July?

Ms McNeill: I am saying that PBAC has a 17-week lead time. An application was put in the PBAC for a biosimilar of Infliximab, a drug that is commonly used in arthritis treatments and gastrointestinal areas such as Crohn's disease. They already have the dossier and the information. It will go through the relevant subcommittees of the PBAC in June and the PBAC will formally consider that medicine for PBS listing. So point one is: is it suitable for being listed on the PBS? Point two is: should it be 'a' flagged for substitution at the pharmacy level or not? That is what the PBAC will decide. I cannot pre-empt a decision of the PBAC, given that they are still considering that application.

Senator CAROL BROWN: I never asked you to do that. I am just asking whether we expect the decision to be made in July.

Mr Stuart: There will be a decision, which will either be to list or to not list; then to 'a' flag or to not 'a' flag.

Senator CAROL BROWN: Okay; that is what I was asking.

Mr Stuart: It may be deferred, it may be refused or it may be accepted. Then the question is: will it be 'a' flagged or not.

CHAIR: We thank you, Ms McNeill and others, for your very comprehensive evidence.

[11:22]

CHAIR: We will now move to outcome 7, Health Infrastructure, Regulation, Safety and Quality. There is obviously a lot in this area. Some senators from outside the committee want to ask questions on NICNAS. I have one of them here, and others arriving. Can I suggest we have some NICNAS questions to start, so they are not hanging around? I will go to Senator Ruston. There are some others; I know Senators Xenophon, Waters and Rhiannon were keen in this area. Senator Ruston.

Senator RUSTON: Dr Richards, probably following on from some questions we have been discussing over the last 12 months, do you have on you these statistics? In the last 12 months how many industrial chemicals were introduced into Australia for the purposes of being used in cosmetics?

Dr Richards: I do not have those statistics on me. I can certainly take them on notice and provide them.

Senator RUSTON: You may have to take all of this on notice, but I would appreciate an answer, too.

Dr Richards: Sure.

Senator RUSTON: In terms of the ones that came into Australia I would be keen to know how many were exempt from assessment and how many required full or partial assessment. Of those assessments, how many of the applicants commissioned animal testing for the purposes of introducing that cosmetic into Australia? Of the ingredients that required full or partial assessment and provided animal testing data, how many of those ingredients are already on an approved list overseas that we would consider a jurisdiction that we thought was safe? Of the animal testing data, how many applicants provided animal testing when NICNAS would have otherwise possibly accepted, or would have accepted, a non-animal-testing opportunity? Do we know how many animals were used? Take those on notice. Obviously if you haven't got the first numbers you cannot answer the rest of them. Do we

know how many animals were used last year for the purposes of testing for the safety of cosmetics in Australia?

Dr Richards: No, I do not believe we would have those data. We could, at significant administrative effort, go through the dossiers provided to us and attempt, where such information is available, to count the number of animals that were used, but that would be a significant diversion of resources.

Senator RUSTON: No, I do not want you to do that. I will explain to you what I am trying to get at; that may assist you in the response. Basically what I want to know is: if we agreed not to accept overseas jurisdictions' approvals, instead of requiring additional testing coming into Australia, how many ingredients would that exempt from requiring testing in Australia? Also, if we mandated non-animal-testing, instead of allowing companies to choose whether they used animals or otherwise, how many ingredients would that remove from the equation? What I would really like to know at the end of the day is that, if we did all those things, how many ingredients would have been imported into Australia in the last 12 months that would have required testing on animals for the purposes of importation as per the guidelines that you operate under? So we can get an idea of the quantum of the testing on animals in Australia. I have not got that answer yet.

Dr Richards: We can certainly do what we can to provide you with information on that, but it is not quite as straightforward as you suggest. Under the Industrial Chemicals (Notification and Assessment) Act there is a schedule to the act which sets out the data requirements for particular categories of chemical. Many of those data requirements refer to animal tests. However, introducers of new chemicals can apply to NICNAS for a variation of those data requirements. I have previously advised this committee that to my knowledge, and certainly in recent times, NICNAS has never insisted that a company conduct an animal test. What I need to be satisfied of—what NICNAS needs to be satisfied of—is that the assessment can be completed with the data provided. In many cases, data provided relate to data from very similar chemicals that might have historically been tested on animals. It might be data that had derived from in vitro or in silico computer modelling tests. Although the schedule data requirements in our act may, on paper, require animal tests, in practice NICNAS does not insist on animal tests being done simply for the assessment of a chemical in Australia. Secondly, different jurisdictions around the world have quite different regulatory systems for industrial chemicals, including cosmetic chemicals. For example, in Europe there is no assessment of the chemicals by a government agency. So there is no list of chemicals that have been assessed and approved by government as such.

Senator RUSTON: How do they get them onto the marketplace?

Dr Richards: It is a completely different regulatory scheme where companies are required to publish a dossier of all the hazard data, which then the regulators can audit, should the regulators choose to do so.

Senator RUSTON: Why couldn't we accept that?

Dr Richards: That is a matter for government policy.

Senator Nash: Senator, I understand there is a significant level of interest around this issue. I am sure Dr Richards, notwithstanding some of the complexities in this area, will undertake to get that information to you as fulsomely as he can.

Senator RUSTON: The bottom line is: if you went to the full stage and banned the testing of ingredients on animals for the purposes of importation into Australia, what is the quantum impact of that? I have no concept whatsoever whether it is going to be a major impact or whether it is going to involve three bottles of face cream coming in next year.

Dr Richards: Again, it is likely to be a commercial decision by individual companies choosing or not choosing to market particular products in Australia.

Senator RUSTON: I need to understand the quantum of what that is. If you come back and say that last year you exempted only six ingredients and you had mandatory non-animal testing at any level of testing for the purposes of importing those products into Australia, then we have got an issue that is really quite small. Whereas if you come back and say there are 17,000 different products that require testing, it is a completely different thing to be looking at. I would like to understand whether—

Dr Richards: Certainly. I am happy to provide the data that we have available to us, on notice. The other important point to note, however, is that Minister Nash has recently announced significant reforms to NICNAS which should also have an impact on the number of chemicals that are likely to require assessment by NICNAS and therefore require data. But the details of those reforms have yet to be worked through. So we could not give you figures on how many would or would not be in different categories because the criteria that determine those categories under the new arrangements have yet to be negotiated with relevant stakeholders, including industry.

Senator RUSTON: Obviously as a result of the reforms that have been proposed by the minister—and we have been privy to the process that has gone into getting to that point—you must have some idea of the quantum of the implications of the changes, even if you cannot be specific about the numbers?

Dr Richards: Certainly. I think it is fair to say that I do not think there is anyone who wants to see animal testing continue any longer than is necessary for the protection of human health. As I have mentioned to this committee before, there is a considerable amount of international scientific effort put into developing new ways of testing chemicals that do not involve the use of animals. A lot of the data that we see is historical data that had been done many years ago on animals or similar chemicals on animals. The number of animal tests that are done these days is much, much smaller, I am pleased to say.

NICNAS, as I have mentioned before, are undertaking a review of a number of the existing chemicals on our inventory that have never been previously assessed and we are looking for what data exists about them so that we could give the community assurances about the safety of chemicals that are in wide use that have never been through an assessment process. As part of that we go looking through all the old dossiers that we can find, particularly the dossiers published in Europe. On occasion—indeed, yesterday I read one of these reports—it is quite heartbreaking to read in reports what was done to animals in the name of chemical safety testing in the past. The approach to animal testing has changed radically over the last decade or so. The number of animals used in tests has been significantly reduced by a concerted effort of international governments.

The number of alternative tests is continuing to increase but there are still some toxicological end points of concern to human health and safety for which there are still no

validated alternative tests. But that is not to say that we at NICNAS insist on those tests being done. It really comes down to a judgment about whether or not we are confident that the risks of a chemical have been adequately assessed without the need for animal tests. As I say, to my knowledge, and certainly in recent years in NICNAS, we have never sent a company away and insisted on them doing an animal test.

Where there is uncertainty because there is no animal test and there is some uncertainty around the safety of a chemical, we tend now to place more stringent controls on the use of that chemical because of that uncertainty that might be there because an animal test has not been done that gives us additional reassurance about its safety. In a regulatory sense we, along with our international colleagues, have been putting a lot of effort into removing, where possible, any need for animal testing.

Senator RUSTON: What would be the consequences of a ban?

Dr Richards: The consequences of an immediate ban would be that the ban would come in before the science is ready to complete the alternative tests, particularly for some of the more complex end points like cancer. Does a chemical cause cancer?

Senator RUSTON: When are those scientific tests likely to come in?

Dr Richards: As I say, there is a huge amount of international research. The research is ongoing. I would be a very brave person to predict a particular time. I think there is a sense of optimism in the regulatory and scientific communities that it is coming. But it will not be here tomorrow. It is a bit like the shampoo and the conditioner: 'It won't happen overnight but it will happen.'

Senator RUSTON: As long as that shampoo and conditioner has not been put in bunnies' eyes. I would be interested—and take it on notice because obviously there are many others that want to ask questions—in your view on what would be the consequences of a legislative ban.

Dr Richards: The fundamental aim of the NICNAS reforms that the minister announced last week is a further reduction in the need for assessment of chemicals that are known or reasonably assumed to be safe. So the number of new chemicals that would be assessed by NICNAS we expect to go down significantly and therefore the number of chemicals with data requirements that might involve the use of animals will similarly decrease. But as I say, it is difficult to quantify at this stage because we have yet to negotiate with all the relevant stakeholders the actual criteria that we use to categorise chemicals for assessment.

Senator RUSTON: I look forward to your responses. Thanks.

Dr Richards: Thank you.

Senator MOORE: I have a couple of questions of Dr Richards. The budget papers talk about $4.2 million over four years to look at streamlined approvals processes. It has got a blurb but in the middle of it has 'streamlined approvals processes'. My understanding is that the full review of NICNAS has not been completed yet. I am interested why we are having a streamlining of processes before the final review is completed.

Dr Richards: The review of NICNAS has been completed.

Senator MOORE: It is just not public?

Dr Richards: The regulation impact statement that informed the government decision, we are awaiting publication on the OBPR website. It is just in the queue of reasons to be published. We are expecting it to be published within the next few days.

Senator MOORE: I know people have been waiting for the review. You are saying that this actual decision was based on the review?

Dr Richards: Yes, that is right. The review of NICNAS started in 2011 and has—

Senator MOORE: We have been asking questions since then.

Dr Richards: I appreciate your interest. The review has been completed. The outcomes of the review were submitted to government in the budget context, which is why the announcement was made in the budget papers.

Senator MOORE: Dr Richards or Minister, can we now have any indication of when the full review document will be made public, particularly as budget decisions have been based on it?

Senator Nash: We are considering that at the moment. I hope to have an answer to that for you shortly.

Dr Richards: What I am expecting to be published is the regulation impact statement, which is the summary of the outcomes of the review and the options that we considered.

Senator MOORE: It is not there either. I have just had a little squiz and it is not up.

Dr Richards: I know. I in fact had a strenuous discussion yesterday with OBPR about its publication. OBPR provided me advice yesterday that I could have published the RIS on my website. My view, in terms of the efficient use of Commonwealth resources, is that it should be published once and then everyone else links to it. OBPR has an obligation to publish all RISs on its website. My advice yesterday from OBPR—because we have been asking the question, 'Can we please have this published because it is of significant interest?'—is very soon.

Senator MOORE: Very soon?

Dr Richards: I have asked for it to be prioritised for publication.

Senator MOORE: How 'very soon' is the streamlined approvals processes?

Dr Richards: The announcement in the budget was for the reforms to be implemented over two years, starting 1 July this year. So in a month's time we will be officially commencing the implementation of the government's decision in relation to the reforms agreed through the review of NICNAS.

Senator MOORE: What are the streamlined approvals processes?

Dr Richards: The implementation details will be subject to further negotiation over the next two years. The reason there is a two-year implementation is the government has agreed to the broad framework to be put in place. In broad terms, it will involve categorising chemicals into one of three classes. If you have a new chemical that you want to introduce, you, as the introducer, need to determine which of three classes it belongs to.

Class one is where the chemicals, most of which would equate to our current exemption categories, can be brought into Australia without notification to NICNAS because they are deemed to be safe. Class two are chemicals that are safe, like polymers. Currently polymers

are of low concern as examples that we assess but, I must say, our assessment does not usually add a lot of value to the risk management process because they are inherently of low concern. Class two chemicals need to be notified to NICNAS but there is no requirement for NICNAS to do a pre-market assessment. So the expectation there is a lot more chemicals that are currently being assessed by NICNAS will proceed to go to market without a pre-market assessment.

Class three chemicals are the more high-risk chemicals that will be subject to both notification and pre-market assessment, as per the current arrangements. But the number of chemicals in class three is expected to drop by about two-thirds.

Senator MOORE: Why?

Dr Richards: Because of the number of chemicals that will be moved into the new class two, which will no longer require assessment by NICNAS.

Senator MOORE: Currently you have chemicals in the 'needing assessment' box that will now be, as a result of these changes, in the 'only to be notified' rather than 'needing assessment'?

Dr Richards: That is right, but—

Senator MOORE: How is that decision made?

Dr Richards: That is a decision of government as an outcome of the review. The decision also included a significant increase in post-market auditing. So NICNAS will have more resources allocated to audit companies to check the basis on which they concluded that it was class two and not class three, for example. NICNAS would have the right under the new arrangements to send a chemical for assessment if there were concerns about its correct categorisation.

Senator MOORE: The supporting material in the budget papers actually says: 'To focus regulatory assessment on industrial chemicals that pose the greatest risk and to develop the streamlined assessments processes for new and existing chemicals, including using international approvals where appropriate.' That is all spelt out in the review?

Dr Richards: That is correct. The fine implementation details of what are the criteria for putting something into class one or class two are the things that we will be negotiating with all relevant stakeholders—not just industry but with all relevant stakeholders—over the next two years.

Senator MOORE: Is there any legislative requirement to start this action on 1 July?

Dr Richards: It is a government decision that we start implementing the agreed reforms.

Senator MOORE: There is no action that has to go through parliament, no regulations, no process of that kind?

Dr Richards: As I say, the implementation process starts on 1 July. It will culminate in revisions to legislation or regulations which will be subject to parliamentary scrutiny.

Senator MOORE: The minister has a report. The report has been used to create the changes that the money has been allocated for, $4.2 million over four years. The consultation process on the report and how it is going to be implemented will start when?

Dr Richards: On 1 July.

Senator MOORE: That is when it will go public?

Dr Richards: That is when we will have the resources to allow us to start consulting. Currently NICNAS has the resources required to do the assessments under the current arrangements. We will continue to do those assessments under the current arrangements for another two years. The government's expectation is that we will have new legislation and regulations and new processes and procedures in place in two years time to implement the new scheme.

Senator MOORE: What will be the process of consultation?

Dr Richards: It will be, I expect, a standard process of consultation where we will put out options papers and discussion papers and have meetings with stakeholders.

Senator MOORE: Over what time frame?

Dr Richards: Over the next year or two.

Senator MOORE: What is the $4.2 million to be spent on? Is it to be spent on that?

Dr Richards: Government has, in the budget process, agreed on the resourcing that NICNAS should have, both to employ sufficient staff to run business as usual as well as to engage in all the consultation and write all the materials and develop all the new processes as well as, obviously, the consultants required and the resources to manage the consultation process.

Part of the reforms also includes the establishment of a new IT system to improve the efficiency of the process. Currently, NICNAS is exempt from the Electronic Transactions Act and we require data on chemicals to be submitted in paper documents. The government has agreed, as part of these reforms, for us to build an IT system that would allow electronic lodgement of data by companies, electronic registration of companies, electronic payment of their levies and fees through NICNAS. The government has allocated a capital injection to allow us, in the next two years, to build an IT system. The costs of the initial reform activities in terms of the staff and the consultation processes will be recovered from industry during those two years. So the NICNAS levies registration charges will increase in the next two years to pay for the cost of implementing those reforms.

Senator MOORE: That will need regulation, won't it, to increase the levy?

Dr Richards: That is true. That is a disallowable instrument.

Senator MOORE: That is right.

Dr Richards: The government is proposing to recover those costs from industry. The government has given NICNAS—or will give it, over the next two years—a capital injection to pay for the IT system rebuild. The government decision is that that capital cost will be recovered from industry over the subsequent five years.

Senator MOORE: The budget statement says it will be fully funded by industry.

Dr Richards: Over seven years, that is correct.

Senator MOORE: First of all, it says that $4.2 million is over four years. So that money is going over four years. You said it was hoped these changes would be done in two years; is that right?

Dr Richards: That is correct, Senator.

Senator MOORE: With the implementation, it will be up in two years. Also the cost will be fully funded by industry from 2015-16 to 2021-22. So over a seven-year period there will be staggered increases to the levy to pay back just the $4.2 million. Is that the only amount of money that is subject to this?

Dr Richards: In the budget papers $2.5 million is allocated for these operational expenses in each of the next two years.

Senator MOORE: That is in another section of the budget.

Dr Richards: Then there is $0.4 million in the last year, 2018-19. The capital injection is $3.5 million per year over the next two years.

Senator MOORE: Which gives a total of what? I did not write those down.

Dr Richards: In each of the next two years it is $2.5 million operational and $3.5 million capital.

Senator MOORE: That is $6 million a year?

Dr Richards: That is $6 million a year for the next two years.

Senator MOORE: I have mastered that. So it is $6 million a year over the next two years?

Dr Richards: Of that, the $2.5 million operational will be recovered from industry in each of those two years. So it will be revenue neutral to government, leaving aside the $3.5 million in capital that has not been recovered in the same years from industry. That capital will be recovered from industry starting in 2017-18 at $1.4 million per year for that year and the following five years. There is also $0.4 million allocated for 2018-19 for operational expenses in the final wrap-up which will also be recovered from industry in that year.

Senator MOORE: Dr Richards, can we get on notice that spread of financial transactions? That degree of detail is not in the budget papers that I have, in terms of how that is going to be planned. It just says it will be between 2015 and 2016. It would be useful to see what component is being recovered at what time. That is in preparation for the disallowable instrument that will go through the standard processes. That gets public consultation as well, to see what industry thinks about it. Because we have not seen the review, was there any indication of the need for increased cost to make all of this happen in the review discussions with all of the stakeholders? It was a very wide-ranging review in terms of engagement with your normal stakeholders. Was there discussion at that time that this was what you were hoping to do and this was what it would cost?

Dr Richards: Certainly, the review was a review of NICNAS, not a review—

Senator MOORE: The whole of the operations?

Dr Richards: by NICNAS. So NICNAS itself did not—

Senator MOORE: But you also did consultations with the stakeholders, did you not, in that?

Dr Richards: The policy areas of the department that undertook the review undertook those consultations.

Senator MOORE: People are now rushing to the table, Dr Richards, to help you out.

Dr Richards: My policy colleagues who did the review of NICNAS; I was the one being reviewed. My colleagues were the reviewers.

Senator MOORE: Colleagues, in terms of the process, it was my understanding, after several of these discussions at estimates, that there was a lot of engagement around the review of NICNAS, because people have considerable interest in this area; is that right?

Mr Barden: Yes, that is right. We held significant consultations over a couple of years. Those stakeholders included industry, public health advocates and environmental advocates. The consultations undertook the form of both written and meeting fora.

Senator MOORE: I am sure we have been provided with the people who came to that, at previous estimates.

Mr Barden: I am sorry?

Senator MOORE: I am sure we were provided with information about who attended some of those at previous estimates, to show the cross-section that were engaged.

Mr Barden: Indeed. When it came to your question about the costs of reform, the indication that was given to all stakeholders through the review process was that once a series of options had been put together, there would be a revisitation of the NICNAS cost recovery impact statement, and that statement would present to the stakeholders what the costs of NICNAS with respect to the new arrangements would be.

Senator MOORE: There was an understanding that there could be an increased cost—just not the level of increased costing?

Mr Barden: Indeed.

Senator MOORE: From that point—

Mr Barden: Senator, let me clarify. There could be a change in costs. So we did not go in and say, 'Be aware that the costs may increase.' It was more that there may be a cost associated with the reform package, offset by benefits that we would hope to accrue from the implementation of the reforms.

Senator MOORE: Offset by the new streamlined arrangements and the better IT system—those kinds of things?

Mr Barden: Indeed, and in particular the implementation of the three-class structure that Dr Richards mentioned.

Dr Richards: OBPR has costed the net regulatory benefit to industry of the deregulated environment. In two years time when these new processes are put in place, the expectation is that it will save industry around $23 million per annum, ongoing.

Senator MOORE: Is that assessment in the review documents?

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

Senator MOORE: I am keen to know when we are going to get to the wider community, that same community that has been watching this process for a number of years, all the information around the review, the costings and the new process, so that everyone will know what is going on. If you are intending the implementation to start on 1 July, I would think that it would need to be done fairly soon. The minister said that she will look at that. For my own peace of mind, I am wanting to know exactly what is in that documentation. It gives a report.

We know in the budget papers that there are changes that are based on that review. We have been told by Dr Richards about the proposal for increased fees, which is also in the budget paper, but not the amounts. What I am wanting to be clear about is that, after all these years, we are expecting that we have all of this information out there in the public view, particularly as you have a commencement date of 1 July. The proposed first range of increases is in financial year 2015-16. Are you nodding in agreement?

Ms Jonasson: I am sorry, Senator; I am not sure what the question was.

Senator MOORE: My question was: do you agree?

Ms Jonasson: Yes, Senator. I would like to reiterate what Dr Richards said earlier about our having continued conversations with OBPR to get that RIS up on the web as soon as possible.

Senator MOORE: Dr Richards, will you be working with the department in the implementation phase in terms of the consultation or will that revert back to the NICNAS process, which you handle normally?

Dr Richards: Under the government decision the resources have been allocated to NICNAS to implement the reforms. NICNAS is part of the department. The staff employed in working on the scheme are departmental officers. As you would expect, the working relationship between the staff of the department working on the scheme and the staff of the department working in the policy areas is very close. I would expect the usual continued, collegiate cooperation between the policy area and the implementation area. The resources have been allocated to NICNAS.

Senator MOORE: That is all I have. In the next estimates we will have a look at what has happened in the next six months.

Senator McLUCAS: I have one follow-up question. What are the considerations that you are having to contemplate in making a decision to publish the review report? Why isn't this being published as a matter of course?

Senator Nash: I think it is nothing drastic, Senator. It is just going through the processes of my having a good, comprehensive look at it. I assume that will be a deliberation that we finish very shortly. I understand the interest around this.

Senator McLUCAS: When did you receive the report?

Senator Nash: I would have to take the exact date on notice, Senator. I cannot remember off the top of my head.

Dr Richards: If I can assist in answering that, Senator McLucas, there is an obligation on the Office of Best Practice Regulation to publish the regulation impact statement as soon as practicable after the decision has been made. These decisions were made in the budget context. Obviously, the number of RISs that informed the budget is a large number.

Senator McLUCAS: I am not referring to the RIS; I am referring to the actual report.

Dr Richards: The RIS is the report.

Senator McLUCAS: They are one and the same?

Dr Richards: They are one and the same document.

Senator McLUCAS: I am clear now; thank you.

Senator RHIANNON: Dr Richards, I also had some questions on NICNAS and animal testing. I came in when you were in the middle of some of your questions; I apologise if I am repeating any. I want to start off with some process questions, so that I can understand the situation. What information does NICNAS require companies to provide about animal tested substances in order to fulfil data requirements set out in the industrial chemicals act?

Dr Richards: I have already answered this question for Senator Ruston today, but I am happy to repeat my answer.

Senator RHIANNON: I will look at it. I did come in while Senator Ruston—

Dr Richards: It is quite simple. The Industrial Chemicals (Notification and Assessment) Act has schedules in the act which set out the data requirements for the different types of chemical assessment. As I pointed out in my answer to Senator Ruston's question, the act also allows the director of NICNAS, or a delegate, to vary those data requirements on application from the company. A company might have an obligation to submit data which might involve an animal test. It is within their right under the act to apply to have a variation so as not to provide those data and to provide other data. Provided that we are satisfied that we can complete an assessment without those data, we usually agree to those variations.

Senator RHIANNON: Following on from some of the discussions about the budget paper and the $4.2 million, I thought it was over four years. I thought at one point in the discussion you said that it was over two years. Could you clarify that? Is that my misunderstanding from the budget papers?

Dr Richards: The primary implementation of the reforms is over two years. The bulk of the funds are in the first two years. There is a small amount of funding in the fourth year. So technically it is over four years. The fourth year figure is $400,000.

Senator RHIANNON: Thanks for clarifying that. In relation to this announcement, what measures will be taken under this framework to ensure a commitment to consumer safety and modern scientific developments through the increased acceptance of non-animal alternative test methods?

Dr Richards: As I answered in my earlier question, the fundamental reform that is being introduced is the establishment of three classes of chemicals with varying requirements for assessment and notification. Class 1 does not require notification or assessment; class 2 requires notification but not assessment; and class 3 requires both notification and assessment by NICNAS. The criteria by which a chemical is allocated to a class, or the criteria that determine the class to allow someone to decide what class their chemical fits into, will be subject to wide consultation with all relevant stakeholders, including representatives of civil society—NGOs, public health and environmental interest groups.

Senator RHIANNON: On the data sharing, will compulsory data sharing be introduced to help prevent the duplication? As you know, one of the concerns is that often there is duplication in animal testing.

Dr Richards: Under our act, there is absolutely no requirement for an animal test to be repeated if it has already been done for the purposes of another regulatory scheme. Under the OECD, Australia is a signatory to what is called the MAD scheme, the mutual acceptance of data, which obviously is anything but mad. For tests, whether they are animal tests or any other tests, that have been conducted in accordance with OECD test guidelines and with good

laboratory practice, all signatories, which is all OECD members plus a lot of other countries that are not OECD members, accept those data without requiring those tests to be repeated.

I think it is also fair to say that NICNAS is an unashamed plagiarist. The first place we go looking is every other regulator and every other scientific source of data that we can find and, if we can find the data that satisfy us anywhere we can, we use those data in our assessments. I do not believe that there is any statutory obligation on us to share data, but it is our standard practice.

Senator WATERS: I have some questions about the national assessment of chemicals in coal seam gas. Is that you?

Dr Richards: That is me again.

Senator WATERS: Thank you, Dr Richards; it is nice to have you here. Last time we spoke, and I do not think I spoke with you last time—

Dr Richards: I think you did.

Senator WATERS: Well, your memory is better than mine; my apologies. We talked about the progress of that national assessment. I understand that was originally due in 2014 but was then pushed back to, I think, mid-2015. It is now basically mid-2015. Do we have an update on when that will be complete?

Dr Richards: The NICNAS website still optimistically says mid-2015. As I have advised this committee on previous occasions, the national assessment of chemicals associated with coal seam gas is work that NICNAS is part of on contract, on commission from the environment department from the Office of Water Science. NICNAS has, during the course of this project, as have the other partners in the project—CSIRO and the committal assessment section within the environment department, with advice from Geoscience Australia—been providing progress reports to the environment department. The environment department has been subjecting those to its internal consultation and clearance processes and we continue to get feedback on those reports from technical editors and the like. We are still in this iterative process of reviewing and revising the reports. Can I confidently give you a date on which those reports will be released? That is a matter, firstly, for when they have actually finished that somewhat iterative process of review and editing and, secondly, it is a matter for the environment minister and his department as to the release of those reports.

Senator WATERS: Thank you for clarifying that it has reached that review and editing process. Can I just confirm that NICNAS's input in relation to the actual amassing of the content has finished?

Dr Richards: NICNAS has submitted what we consider final draft reports.

Senator WATERS: You have done your bit and now you are waiting on them.

Dr Richards: But we continue to get questions and suggested edits. From our point of view, we are continuing to finesse the documents, taking into account feedback from a range of sources, largely mediated through the environment department.

Senator WATERS: Thank you. I will take that up with them at the next opportunity. Thank you for explaining the reason for the delay. Is that a standard delay, or did you get the sense that it was taking a particularly long time for that review process?

Dr Richards: I do not think I have an opinion on that.

Senator WATERS: Okay. I do not know about these things; but that is all very mysterious. Last time we talked about the scope of that assessment and you confirmed that it was to do with surface water and shallow ground-water. But my recollection is that it was not looking at the impacts on deep aquifers.

Dr Richards: That is right. I answered a series of questions, which I have seen that you have put on your YouTube channel.

Senator WATERS: Yes, you are famous now.

Dr Richards: I am famous now. The scope of the project was set a number of years ago by the Office of Water Science on advice from the Independent Expert Scientific Committee on Coal Seam Gas and Large Coal Mining Development, based on contemporary concerns at that time. We are all aware that that is not all the concerns but, as with any project, scope creep is probably the hardest thing to manage. It is not a refusal to recognise that there are other issues that might need looking at; it is: this was the agreed scope of this particular project for this particular amount of funding that was provided, and it is a matter for the environment department as to whether they commission further work.

Senator WATERS: Has there been any suggestion or indication from either the Office of Water Science within the department or the independent expert scientific committee that they are aware that, as you say, the concerns are no longer just about shallow aquifers and surface water—if they were ever only about that? Is there any move to expand out the scope of that assessment to now look at deep aquifers?

Dr Richards: Certainly I would not be surprised if the Office of Water Science and the IESC were aware of those concerns. The extent to which they are contemplating that is not a matter for me to comment on.

Senator WATERS: So you have not yet been asked to expand the scope of that assessment?

Dr Richards: We have not been commissioned to do any further work at this point, but that does not preclude them asking us tomorrow.

Senator WATERS: We live in hope; thank you. Recalling again that that national assessment just looks at coal seam gas and does not look at shale gas or tight gas, for that matter, is there any expertise within NICNAS to establish whether the threats from the fracking chemicals used in shale and tight gas are comparable to the threats posed by, essentially, similar or the same chemicals as in coal seam gas?

Dr Richards: NICNAS's expertise is in assessing the risks of chemicals. As you would be aware, the way you do a risk assessment is to first look at the intrinsic hazards of the chemical, which are the properties of the chemical itself, and then look at exposure and the way in which people or the environment are exposed to the chemical. One of the challenges or activities within the current project has been that, prior to this project, there were no reliable methods for measuring exposure from that use. That will be, I think, a significant outcome of this project. The reason there were a number of partners to this project, including the CSIRO, was to develop those exposure models. I would expect that those models may well be able to be adapted for other related mining activities, but that is a technical question for those—

Senator WATERS: Sure; again, we live in hope. Can you just tell me a little bit more about what questions those exposure models help you to answer?

Dr Richards: The exposure models are looking at the degree to which workers, the general public and the environment are exposed to the chemicals that are used in hydraulic fracturing and drilling for coal seam gas.

Senator WATERS: That, you say, is something that we have not yet had a model for, despite the fact that there have been multiple approvals for coal seam gas right across the country issued.

Dr Richards: The models have been developed as part of this project and obviously we have been providing ongoing reports to the environment department.

Senator WATERS: Are you aware of whether they have used any of the models in their assessment processes under the EPBC Act?

Dr Richards: That is not a matter on which I can comment; I am not aware of that.

Senator WATERS: We can probably work that out from the time frame. When did you provide them with a usable model?

Dr Richards: NICNAS does not provide those exposure models; that is a CSIRO input. I am not in a position to comment on that.

Senator WATERS: Are you aware of when CSIRO provided the model to the department?

Dr Richards: I do not have the date with me.

Senator WATERS: Do you have a rough estimate?

Dr Richards: I think that might be a question best put to the Office of Water Science.

Senator WATERS: Anyway, my point remains: it is great that this work is now being done. What a shame that it has come after most of the key approvals have already been issued. But that is obviously a matter for the minister—

Dr Richards: It is not a matter that I can comment on.

Senator WATERS: And not a matter for NICNAS. I have asked you this before and forgive me for asking again, but I have forgotten what you said. With that exposure model, you are talking about fracking chemicals. Have you looked at the impacts on, as you have said, workers, the general public or the environment from the mobilising of naturally occurring BTEX in the fracking process itself?

Dr Richards: As part of the broader project, CSIRO has done some work on identifying chemicals that might be mobilised, the so-called geogenic chemicals. But, as you know, NICNAS's role is the risk assessment of industrial chemicals, which are chemicals—

Senator WATERS: Right; so that is beyond your purview.

Dr Richards: We have not done a risk assessment of those chemicals, but the identification of those chemicals is part of the project. If asked, we may be able to do an assessment of those risks, but that is not part of the current scope of the project.

Senator WATERS: It is something that might fall within your scope of responsibility, but it has not yet been given to you to do that?

Dr Richards: It would not fall within the scope of our statutory responsibility, but it might fall within the scope of our expertise.

Senator WATERS: That is interesting. I will ask you next time whether anyone has asked you to factor those risks in.

Dr Richards: But there would be other people who could equally provide that advice. I would not say that we have a monopoly and we have an automatic right to be contracted on this matter.

Senator WATERS: Sure. I understand that, in the 2014 budget, there was an announcement that the Office of Water Science's research program would be abolished come 30 June next year, with a saving of $10 million over five years—and of course an avoidance of the amassing of all sorts of useful knowledge. Are you aware whether there has been any work that NICNAS might have had the chance to participate in should that funding stream have continued?

Dr Richards: NICNAS has had no guaranteed funding. We have undertaken the current project on the basis of it being commissioned for this project. We have no right or expectation to be contracted for any other work. That is a question for the Office of Water Science.

Senator WATERS: So there were never any discussions about potential work that that office research program could have funded that it obviously now cannot because it is going—

Dr Richards: As I answered to a previous question, the officers are departmental employees of the Department of Health who, as you would expect, have conversations with other public servants across government on a range of issues. There have been no contract negotiations—

Senator WATERS: What was the subject matter of the potential scope of that work?

Dr Richards: There has been no specific scope mentioned. When you agree on a scope, you agree on what you are not currently doing. Whether that might form the basis of a further work is a separate contractual discussion.

Senator WATERS: The funding for the national assessment—does that come from that stream that has now been abolished into the future?

Dr Richards: I know it comes from the Office of Water Science. Whether it comes from that particular funding source, I have no idea. That is, again, a question for the Office of Water Science.

Senator WATERS: Thanks very much for your time. Thank you, Chair.

[11:20]

CHAIR: As we are done with NICNAS, we will go to other parts of outcome 7. I am not going to do it in a strict way, but I know that Senator Ruston had a few brief questions on e-health. Given that she has to go, I might just give her a few minutes and then we will move on to other questions. Senator Ruston.

Senator RUSTON: My questions are around e-cigarettes or e-vaporisers, or whatever they are supposedly called. This is probably for the TGA, is it?

CHAIR: I was told it was e-health.

Senator RUSTON: Is that not the right place?

Mr Bowles: I think that would be in population health.

Senator RUSTON: So which one is this one under?

CHAIR: This is e-health. There are other aspects but—

Mr Bowles: E-cigarettes is a mix of TGA and population health, so you will only get part of the story.

Senator RUSTON: So it would be better to come back to it.

Mr Bowles: In population health.

Senator RUSTON: Brilliant. That was quick.

CHAIR: Thank you, Senator Ruston.

Senator McLUCAS: While we have e-health, we may as well do those questions now.

CHAIR: Sure. Senator Moore?

Senator MOORE: I just have a few questions on e-health. Welcome, NEHTA.

Mr Madden: Thank you very much.

Senator MOORE: I want to know how many e-health records have now been created. What is the current state of play?

Mr Madden: To date, as of midnight last night, for individuals registered, we have 2,242,823.

Senator MOORE: Has there been any kind of goal set, say, that you wanted to reach a certain number by a certain time?

Mr Madden: The last goal would have been in June 2013, when we had a target of 1.5 million.

Senator MOORE: Did you meet it?

Mr Madden: We achieved that target before the June mark. Probably around April, from memory, we reached 1.5 million, but it has been growing naturally ever since.

Senator MOORE: Now it is just growing and there is no particular target that you have in mind.

Mr Madden: Yes.

Senator MOORE: How many new records have been created since we met last in estimates?

Mr Madden: I do not have that with me; I am sorry.

Senator MOORE: Just take that on notice. We want to see the growth trajectory as it goes through.

Mr Madden: I can say that the average growth rate on the natural growth of individual registrations is running at about an average of 2,000 per business day, so around about 10,000 per week is what is happening.

Senator MOORE: Is that a pretty solid average?

Mr Madden: Yes.

Senator MOORE: What has the government done to promote the take-up of e-health records in this period; what has been the promotion strategy?

Mr Madden: Up until recently we were still waiting for the outcome of the review into the PCHR. We had done little, other than to have people asking for information or particular communication material to provide to their local individuals or health care providers—again, in awaiting the outcome of the review. I guess with the announcement of funding post review, which gives us three years of operational funding, we can now commit to a communication, education and stakeholder management strategy, which we are working on at the moment. We will be doing that in consultation with our key stakeholders.

Senator MOORE: So the review has now been completed and announced?

Mr Madden: Yes. The review was completed in late 2013 and released in May 2014 and the outcomes announced as part of the budget decisions just in the last couple of weeks, in mid-May.

Senator MOORE: So that is the budget that has set aside $485 million over the next four years; is that right?

Mr Madden: Yes.

Senator MOORE: In terms of the activity over the last two years to pursue the e-health record, what activities have taken place to do that? What actions have been taken over the last two years to ensure that e-health records continue to be monitored?

Mr Madden: To be monitored?

Senator MOORE: To be put into the system and then maintained.

Mr Madden: Sure. Since 2012, when the system was implemented, we have had a strict regime of operational maintenance of the system, which includes monitoring of all activities, monitoring of the clinical safety of the records involved, monitoring for errors and particular issues, such as complaints reported by individuals, including privacy breaches. Those staff and resources have continued to be there and to be funded through until 30 June 2015, the last budget outcome—sorry, the budget from 2014.

Senator MOORE: That was the year—

Mr Madden: That is right.

Senator MOORE: keeping you going.

Mr Madden: Yes. So we had one year to keep going while we went through the consultation and further work on the implementation plans for recommendations of the review. We employ a workforce which monitors progress, activity and security and all of those things around the system. They have continued to do that, and will continue to do so now for another three years through the optional funding for the system as well.

Senator MOORE: What consultation has been had with the medical profession regarding the decision to shift to the opt-out system?

Mr Madden: The recommendations from the review were to increase participation in the system. The health community had said, 'If we had the majority of our patients in the system, we would be more compelled and likely to take this on and use it.' That came through in the form of submissions from the AMA, RACGP, Consumers Health Forum and others—

Senator MOORE: That was prior to 2014.

Mr Madden: That was in 2014, in the report. We did do some consultation directly with health care providers and the community between July and September 2014 just to confirm views about how that would work. The point I need to make is that opt-out, in the current budgetary decision, is to trial opt-out in at least two geographical locations to understand the issues and make sure that we have continued to maintain the consumer's or individual's confidence in the system and to understand the issues that might come with that. So we have not taken a decision to move completely to a national—

Senator MOORE: But you have made a decision to go to the trial of two opt-outs, which is a distinct change from the other process. This committee did an inquiry into the original legislation and the opt-in/opt-out model was a great point of contention at that time. So now, as a result of the review, we have gone with a trialling of opt-out.

Mr Madden: Yes.

Senator MOORE: What form are the trials going to take; has that been determined?

Mr Madden: We are looking at least at two trial sites. We are working with states and territories through the Australian Health Ministers Advisory Committee on the possible selection of sites. We need to find sites which are discernible so that people who are in the sites in the trials know that they are in the trials and people who are outside know that they are clearly not. So we will be doing consultation on the location of the trials. We will be trialling our communication processes and also working through education, communication and training for GPs and other health care providers in the trial sites. While the population and the individuals in those areas might have a registration, we want to make sure that the health care providers are engaged with that system as well. That is why it is important to work with the states, so that we have a connection through the public hospital system.

Senator McLUCAS: Are you proposing to use a PHN boundary for those trial sites?

Mr Madden: Not necessarily. The trial population that we are looking for across, again, a minimum of two and a maximum of five, would be about a million people. So it would probably be an amalgam of some PHNs and it could be based on postcodes that join a couple of PHNs together. We want to get a spread that includes lots of people or individuals and lots of GPs and specialists, allied and private, and public hospitals to get the whole connected community of health care providers for that community involved.

Senator MOORE: Have the terms of the trial been determined yet?

Mr Madden: No. Where we have got to at the moment is to describe the criteria that would pick out what those trial areas might be. We will be looking to appoint an independent person to create the evaluation criteria for that, certainly well before the trials begin.

Senator MOORE: Is all that covered in the $485 million?

Mr Madden: Yes.

Senator MOORE: So that whole process of trialling is involved in that as well as the ongoing operations of the existing processes?

Mr Madden: That is right.

Senator MOORE: In e-health—

CHAIR: Senator Moore, I am sorry to cut you off. I am going to have to be very sharp with the time of 12.25 and I know that Senator McLucas has some housekeeping she wants to

do. So can I get this to be the last question for now? We can come back afterwards, if you would like, and then I will go very briefly to Senator McLucas before the lunch break.

Senator MOORE: Okay. We will go to Senator McLucas.

CHAIR: Thank you, Senator Moore.

Senator McLUCAS: And then I will come back to e-health after lunch.

CHAIR: Yes; that is fine.

Senator McLUCAS: There are a couple of things that I want to fix up from yesterday. Mr Bowles, you took on notice for me yesterday a question that was around costings for coalition policy on hospital funding. I asked a question and you said that you would investigate and come back to us.

Mr Bowles: Yes. I still do not have an answer yet. Was this the 50 per cent issue?

Senator McLUCAS: The 50 per cent growth fund, yes.

Mr Bowles: I do not have an answer. I will follow that up over lunch and see what I can find out.

Senator McLUCAS: Thank you. The other question that I have goes to some clarification around the Tax and Superannuation Laws Amendment (Medicare Levy and Medicare Levy Surcharge) Bill explanatory memorandum. That is not your bill, but you, I hope, have been consulted on it. On page 7 of the EM for the bill there is a table about which we would like to get some understanding at a later point in the estimates, if that is possible.

Mr Bowles: What was the bill?

Senator McLUCAS: It is the Medicare levy and Medicare levy surcharge bill. It is a Treasury bill, but if affects us. If I could have a conversation with someone about that at an appropriate point some time today, that would be great.

Mr Bowles: We will see what we can do but if it is a Treasury bill I may not be able to shed too much light on it other than what involvement we have had.

Senator McLUCAS: Okay; thank you.

CHAIR: Thank you. We will suspend proceedings now.

Proceedings suspended from 12:24 to 13:28

CHAIR: We will recommence and I will go to Senator Moore.

Senator MOORE: I was just talking with you, Mr Madden, and also with NEHTA about the opt-out trials and in terms of the process you said you were going to look at two sites. Is that right?

Mr Madden: Yes. We are looking for a minimum of two sites. We do not want to go any larger than five. Again, we have criteria that would describe what would make for the best sites or not for the best sites. Did you want to know about the logistics of the opt-out?

Senator MOORE: Yes, I do, because of the process.

Mr Madden: By September we are looking to have the sites selected. In the funding for the opt-out trials or what we have called the participation trials, we have funding for education, communication and training for healthcare providers and certainly a heavy dose of communication for individuals in the areas so they are aware of what this means to them,

what they get as a benefit, what their rights are and what they do if they choose to opt out. We would be looking to do that from early 2016 with the training starting around about the same time for the healthcare providers.

We then have a period for two months where we have a system available for the communities to inquire and get information about staying in the system or opting out of the system. They will have a system where they can indicate their expectation or their option to opt out of the system and after that two months we will create skeleton eHealth records for all of those people who did not choose to opt out. We will then give them six weeks or so for them to log into and take control of their records, if that is what they choose to do, because the eHealth system will still have the patient or the personally control aspects. They can still determine who can operate their eHealth record on their behalf, healthcare providers that might be allowed to or not allowed to upload records to their record and who can or cannot see particular records. They will have five weeks to take control of those and to put all of those controls in place if that is what they choose to do. Then about two weeks after that we will create the records. We are looking to target that for having records in the hands of healthcare providers and individuals after the controls have been set some time during July 2016.

Senator MOORE: So it is just over the year?

Mr Madden: Yes.

Senator MOORE: For the option to opt out you have to have them all in first. Are you going to have to put trial sites where there are a lot of records already in the system?

Mr Madden: Part of the criteria—and this is something that has been suggested by our colleagues at the states and territories—is it would be best to go into areas where there is a degree of innovation. Whether that is involving people with a high level already registered in the system, I think it is one of those things that if you went into an area that was quite publicly saying, 'We don't want to use the system', that would give you a different view.

We have said we would look at places where there is innovation and use of technology from both the community and the healthcare providers' perspective as well as innovation in terms of using sharing and communicating across the health community in those areas. Again, we are looking for the states and territories to come back with some suggestions on where those areas might be.

Senator MOORE: So, you would be signing up new people. In my mind, when it was opt out I was thinking it was people already in that were opting out, but this is signing up new participants who can choose to be in and out?

Mr Madden: That is right. The average is running at about 10 per cent of the community who have already registered into the system themselves. If they are in the opt-out trial area they will be in the system already. It will only be those people who have not previously registered that will go through that opt-out process. If somebody does opt out and they choose later on to come back into the system they will be able to do that and if somebody fails to opt out because they either did not understand or they did not know that that was their decision at the time they will still be able to delete that eHealth record, as they can today, if they are registered.

Senator MOORE: So, at the moment everybody is either in the opt-out system or the opt-in system?

Mr Madden: That is right. The current system is an opt-in system.

Senator MOORE: That is what I thought.

Mr Madden: Everybody who wants to be in it needs to go in and consent by registering into that system.

Senator MOORE: So, that is the standard.

Mr Madden: Under the opt-out system everybody will be a member of that system unless they choose to opt out.

Senator MOORE: That is where I am having trouble with my thinking on the process. I can understand people opting in, but if you are not in there already. We can get the format of that. Do you have the guidelines of that public about how the trial will work?

Mr Madden: No. We have one more round of consultation with the states and territories later on this month.

Senator MOORE: When is that due?

Mr Madden: This is on 11 or 12 June.

Senator MOORE: That is a standard representatives from the states that will get together?

Mr Madden: Yes.

Senator MOORE: So, this should be all up and running. You went through the timetable before, but it should be early in the new year. I am just wanting to check the funding.

Mr Madden: All of those will be in place in the system in use from July 2016.

Senator MOORE: I was thinking the implementation process would be starting in the new financial year.

Mr Madden: That is right. It will be after people come back from holidays.

Senator MOORE: I would like to check on the money in terms of the process. Is the $485 million the full funding for eHealth for the next four years?

Mr Madden: We have three years funding for the operation and redevelopment or enhancement of the current system.

Senator MOORE: Is that separate funding?

Mr Madden: I am sorry?

Senator MOORE: I would like to know exactly how much funding you have. You had one year carryover from 2014-15. How much was the funding for the 2014-15 year?

Mr Madden: It was about $140 million.

Senator MOORE: So, that was standard operations for one year?

Mr Madden: Standard operation plus some consultation on the key recommendations from the review to formulate a package.

Senator MOORE: So, now for 2015-16 through until 2017-18 you have $485 million in total?

Mr Madden: We have $485 million, which will take us through to 2018-19.

Senator MOORE: And that is based on?

Mr Madden: We have three years of that for the operation of the system. So, $426 million of that is for the operation and redevelopment of the system to work on useability, clinical content and clinical workflow. We have four years funding for the other aspects of the package, which is the opt-out trials and the changes to the governance arrangements. That is the four years. We will be coming back to government during 2017 with some recommendations on the basis and on the outcomes of the trials to recommend a way forward either in continued opt in or move to opt out.

Senator MOORE: So, at this stage you have no money beyond 2018-19?

Mr Madden: That is right.

Senator MOORE: And the expectation is you would come back to government for that?

Mr Madden: Yes.

Senator MOORE: In terms of the process you have just given me. I have not written that down as neatly as I had hoped, but in terms of that how does it compare with your previous funding proposals?

Mr Madden: As in previous years' funding that we have been given?

Senator MOORE: Yes.

Mr Madden: One of the headlines on this one is we have actually got three years of operational funding, which is the longest period of operational funding we have ever had. The annual cost of that operational funding is incrementally greater than the operational funding for the current year and for previous years because the size and scale of the system continues to grow. There is a minor incremental growth in the operational costs in there, but there is also some money in there in the operations to do some of the enhancements to the system. We need to continue to make it more useable for clinicians and continue to make it more useable and the information more accessible, particularly in the eyes of an opt-out trial where we need people to be able to regularly understand what this system can mean for them so the questions that they would need to be answered will in fact be answered by our information.

Senator MOORE: You think there is a marginal increase on previous estimates?

Mr Madden: Yes.

Senator MOORE: The advantage for you is having three full years of funding?

Mr Madden: Yes. That three years of funding is certainly a strong sign to the health community. In trying to get other software vendors to join up and connect to the system the question was, 'So, what happens after 30 June?' So, it is three years continued. As I said, that is the longest period this program has been funded for in an operational sense.

Senator MOORE: When we spoke last you were saying that state hospitals were now signed up. Is that all state hospitals now signed up? The last time I spoke with you Queensland had just signed up.

Mr Madden: We have hospitals in every state signed up.

Mr Fleming: At this stage we have 399 hospitals from the public sector signed up. That comprises 152 in New South Wales; eight in South Australia; one in ACT as there is only one

public hospital in the ACT; 219 in Queensland; four in Tasmania, which is all of their public hospitals; eight in Victoria; two in Western Australia; and five, which is their total, in the Northern Territory. We are working with the states that are not fully functional at the moment and with those hospitals of course, as you would expect, it is a hospital-by-hospital process, but those 399 are linked through. You can expect to see the public hospital numbers grow. In addition to that, we recently issued an invitation to the private sector.

Senator MOORE: That was my next question.

Mr Fleming: Seven contracts have now been signed with members of the private sector where we are working with their companies to link them through. That is another group that we are negotiating with at the moment.

Senator MOORE: That is your first access to private hospitals?

Mr Fleming: Private hospitals, absolutely. The intention there is they will link into the identifier systems but also into, obviously, the PCEHR to view it and to send a discharge and over a period of time some additional functionality will be added.

Senator McLUCAS: When the Senate select committee was in the Northern Territory recently we had evidence from clinicians and Aboriginal controlled health services in the Territory—and my recollection is NT Health but that may not be correct—saying that their eHealth system in their hospital system was brilliant and there was not the take-up of PCEHR because they were ahead of the game. What is your view of that assertion?

Mr Madden: If we go back in time in the Northern Territory, the My eHealth record system has been running successfully for a number of years. A key difference between their system and the personally controlled eHealth record system is that the person controlled it and the individual's ability to see their record. Northern Territory have been undergoing a transition from their My eHealth to the national personally controlled eHealth record and they are probably 90 per cent of the way through in transitioning across to the PCEHR. They are running through the process at the moment in registering people into the PCEHR. I think the last number I heard was 20,000-plus out of the 56,000 that were registered before, but the target is across the next six to nine months to get the remainder of that population through as they visit, on an opportunity basis, to the various clinics or hospitals in the Northern Territory.

The intention is that after a period of time they will keep access to the historical records in the My eHealth record, but it will be the case that all of the clinicians in the hospitals and the government funded primary care services will all be accessing their patient records through the PCEHR chart or into the future into the My eHealth record.

Senator McLUCAS: The other issue that they raised with us is connectivity and how difficult it is in particularly more remote areas to download. We were at an art show in Katherine that is a bit out of town and sometimes it takes them 20 minutes to download a record, which means that clinicians will not be entering as we are going through and then the inevitable delay. Maybe the record is not even entered. That is not your problem.

Mr Madden: Collectively, it is one of those things that has to improve otherwise the records will be ignored.

Senator McLUCAS: They did say to us that their NT record could not 'talk to' the PCEHR. Is that true?

Mr Madden: Probably the best way of describing that is that the people who are registered in the Northern Territory's My eHealth record system are in there as a consent into that particular system. The consent model for the personally controlled eHealth record is different so we actually need the patient's consent to be there. The movement of the patients, the movement of the records at a technical level in being able to read them through the various software is all there as capacity at the moment. As I said, they are moving that functionality across with the view into the longer term to actually shut down their own local services and rely solely on their clinical software. There is two main GP software variants used generally in the Northern Territory or the top end of Australia. They are all capable of connecting to, to both upload documents and read documents from the PCEHR. At the moment they are able to run in both modes, to talk to the My eHealth record as well as the PCEHR but into the future they will just be talking to the national system.

Senator McLUCAS: Thank you.

Senator MOORE: What is the take-up amongst GP services at the moment? Do you keep data on that? What are the obstacles? Are they still the same as they were in the past?

Mr Madden: They continue to grow gradually. The questions we were getting from some of the consultations with the GP community or the healthcare providers at large were, 'Should we get involved in this? Will you still be here in 12 months, nine years, six months and now three months?' I think the expectation would be that that will start to grow. The commitment to the system being there is one of the factors. Having the majority of the patients registered in the system so that more than two out of 23 of their patients walking through the door will have one is something that will bring them in there, too.

We have a situation where some of the training which was delivered to GPs two or three years ago, if they have not accessed and used the system since they were trained they will need a refresher because things have changed a lot since then. We had a lot of useability problems. Our colleagues from NEHTA have worked closely with clinicians to work through the useability issues through the software that GPs actually use so that has improved.

In the operational funding we also have a review of the GP incentives. The incentives will be paid as an entitlement to those who use the system to upload records on behalf of what I would call their most in need patients. They will be the ones who have care plans. We would be looking for a shared health summary for a small proportion of their total patient base. That will be the set of what is the entitlement for the incentive as opposed to the past where it has been access to a system, registered to use a system and able to use it, but not necessarily use it. I think we are moving to that next phase now.

In order to deal with the gap between those who are prepared to use the system with confidence and those who are not, we will have training available. We will have the online self-directed resources for GPs to work through at their pace in their own timeframe all the way through to training systems so they can actually create patient records which are not for real patients and they can practise with creating those, changing them and getting familiar with the system all the way through to face-to-face training if that is what it takes. We have that factored into our work with that training commencing from later on this calendar year, from October, with those new incentives looking to be in place in early 2016 for all GPs across the country.

Senator MOORE: Does it cost them to be on it?

Mr Madden: Does it cost them to be on it?

Senator MOORE: Yes. Some claim that it does.

Mr Madden: I think there would be a perceived cost in needing to learn and become familiar with the system because it might take a little more time. The question is: what is the value in the investment of the time? I think there is an acceptance that, 'There is a business case for doing that, but if I am the only one doing it what's the point?' I think the bigger the population we get the better. In filling up the gaps of, 'Do I have the capacity? Do I have the knowledge? Do I have the confidence to use it?', we need to make sure they do and can use this confidently in front of their patients. We need to work through that process to get them across the line.

Senator MOORE: Do you have any figures of percentages of GPs? You keep the public hospitals but do you have any data that can tell us the percentage? You can take that on notice.

Mr Madden: We have numbers of practitioners registered in the system at the moment.

Senator MOORE: Are they practitioners or practices?

Mr Madden: Practices.

Senator MOORE: So, it is based on the practice?

Mr Madden: Based on the practice. So, 5,189 practices. Mr Fleming has already told you about the hospitals. There is over 1,100 retail pharmacies, 144 aged care residents services and another 1,099 other categories of healthcare provided.

Senator MOORE: So, is it growing?

Mr Madden: It seems to be growing at around about 34 or 35 per month.

Senator MOORE: Is it still mostly in New South Wales?

Mr Madden: New South Wales is certainly a high scorer. New South Wales is still running at 31 per cent. Victoria is at 23 per cent and then it scales down from there.

Senator MOORE: Queensland is quite low?

Mr Madden: Yes. Queensland is running at 20; South Australia is at nine; Western Australia is at 10; Tasmania is now running at about 10; ACT is running at about 10, as well as the Northern Territory.

Senator MOORE: Thank you very much.

Senator McLUCAS: I would like to ask a follow-up question around take-up. When we made the investment in 2013 to encourage people to enrol what were the daily numbers of people who were enrolling with the PCEHR? We actually invested money to get capacity into the system; is that what is holding us back?

Mr Madden: Yes.

Senator McLUCAS: We have more people in the system demanding of their doctor that they want to be using their record electronically.

Mr Madden: We will try to find the numbers back in the days when we were doing the assisted registration. The key point made in many of the submissions to the review was about

getting the majority of patients registered into the system. The two ways you can do that is to invest in getting people to register in a system or a system then to register in the system and pay the cost for that. The alternative is to take away the burden for people who need to spend potentially up to an hour to learn about the system, register in the system and then get on with it.

Those two are really what we are looking to test through the process of the opt-out trials. There is a burden there for people to register. There is also the data in the matching pieces; if it is done at an assisted level where the keyboard work or the data input work is done when the person is not there anymore we get a high level of errors as well.

Senator McLUCAS: Has there been any consideration of investing in assisted enrolment?

Mr Madden: We have that as one of the options. The costings for that and the timing to do that are the two things would be compared against what the opt-out process would give as a possible alternative. The known costs are somewhere between $30 and $38 per person to do the assisted registration. If you scale that up into the whole community you are into hundreds of millions of dollars.

Senator McLUCAS: I am not suggesting the whole community but perhaps setting another target would be something reasonable to do. You are not saying that we will trial the opt-out model and not bother about any assisted enrolling or will you do both?

Mr Madden: We will be running some trials in the opt-in mode. We will call them opt-in trials. Noting that the rest of the country is in opt-in we will be inviting primary healthcare networks to come to us with some innovative ideas on how they might energise their community to join up, both from an individual's perspective and from a healthcare provider's perspective to compare that against the opt-out trials. We need to look at those innovative ways of driving that up. It is not necessarily just clipboards and people walking around with assisted registration but looking at other ways of getting their communities to work this through.

Senator McLUCAS: Thank you.

Senator MOORE: I am just playing with my figures, which is always nasty. You had $140 million last year as the full allocation and you have $485 million across four years into the future. That is not $140 million a year?

Mr Madden: We have funding for the trials and the governance arrangements for a four-year period, but we have funding for the operation of the system for three years.

Senator MOORE: We went through that before. What is the total?

Mr Madden: The total for the three years operation is $426 million.

Senator MOORE: Which is closer to the $140 million, but that is for three years?

Mr Madden: Yes, but the $140 million had more than operations. It actually had the consultation process.

Senator MOORE: Yes. You talked about consultations and different things. I am wanting to find out exactly how the core funding is going with the operational needs that you have. So, you have the operational needs to keep going in just your standard program of putting the system out into the area and signing up and then you have got an overlay of the specialist

commitment for the trials for the opt-out. I am trying to see exactly what the financial processes are there. Can you give that to me in a document?

Mr Madden: We will take that on notice. The clarification is the $426 million is an amalgam of the operation of the system, the enhancement of the system to increase the useability, to increase the clinical content and the clinical workflows at the practitioner level, as well as the education and training for the GPs in order to meet their incentive entitlements.

Senator MOORE: So, that is operational plus two special projects?

Mr Madden: Yes.

Senator MOORE: That is the $426 million?

Mr Madden: On top of that, we then have the trials, which is about $50 million and about—

Senator MOORE: It would be really useful if you could give that to me in a document that I can understand.

Mr Madden: We will give you a nice table.

CHAIR: That is all on eHealth. I am in your hands.

Senator McLUCAS: Can we have Organ and Tissue donation.

Mr Bowles: I can just respond to a question. Senator McLucas asked me before lunch around that Medicare Levy Surcharge. It is a question best asked of Treasury, because the comparison page that you referred to, I think it was page 7, just changes the income. We do not have anything to do with that. That will be a Treasury issue.

Senator McLUCAS: So, you were not consulted around that at all?

Mr Fleming: We would not necessarily be consulted about changing income thresholds. That is a Treasury related issue.

Senator McLUCAS: We will do that through Treasury. I thought we may be able to get a quick answer so we do not have to write you a letter.

Australian Organ and Tissue Donation and Transplantation Authority
National Blood Authority

[13:55]

Senator McLUCAS: Has the merger of the Organ and Tissue Donation and Transplantation Authority and the National Blood Authority been progressing smoothly?

Mr Bowles: We are still developing the strategy along the way. There is no final outcome on that at this particular point, but we are still progressing along those lines.

Senator McLUCAS: You sound a little tentative. What are the obstacles?

Mr Bowles: None. No particular obstacles. We are just trying to work through a range of issues there and what is the best approach for some of these issues.

Senator McLUCAS: What sorts of issues?

Mr Bowles: It is a decision before government.

Senator McLUCAS: I thought it was a decision of government?

Mr Bowles: Yes. We are working through a range of the colocation, the combination and all those sorts of issues. That is advice before the minister at the moment.

Senator McLUCAS: Have any external consultants been hired to advise on the merge process?

Mr Bowles: I will take that on notice, but I am not aware of any.

Senator McLUCAS: What has been the cost to date, both departmental and potentially external, of the work that has been undertaken to merge the two authorities?

Mr Bowles: I am not aware of any external advice on any of that. I can take that bit on notice just to clarify for you. Apart from that it would be internal resources and we would not necessarily cost that because there would be a few people doing work around that.

Senator McLUCAS: We would like to have a bit of an understanding of what the cost is.

Mr Bowles: Yes. We can take that on notice.

Senator McLUCAS: For the department and if there is any external?

Mr Bowles: If there was external.

Senator McLUCAS: The newly merged entity is to commence operation on 1 July 2015. Is that still on track?

Mr Bowles: That will be an issue for the minister to ultimately decide. I do not want to pre-empt where that may land.

Senator McLUCAS: Minister.

Senator Nash: Given it is early June I think that is an ambitious start date of 1 July, but we are certainly still working to that.

Senator McLUCAS: So we are still working to merge the entities to start on 1 July?

Senator Nash: We are still working to do that. We are continuing to do the work on the draft legislation and we are still, at this stage, moving to that.

Senator McLUCAS: Is there a legislation requirement?

Senator Nash: For the legislation to go through the parliament?

Senator McLUCAS: Yes.

Senator Nash: There is. That is why I was saying that the draft legislation is being worked on now.

Senator McLUCAS: Are you expecting it to go through the parliament before 1 July?

Senator Nash: I do not expect anything but the intent is still to work to the 1 July date.

Senator McLUCAS: We have not had the bill presented yet, have we?

Senator Nash: No, we have not. That is why I was saying that it is still a draft. I am sorry I was not very clear.

Senator McLUCAS: Let us go to the rates of donation. Ms Cass might be able to help us here. Rates in the last couple of quarters have not been as successful as we would have expected. Can you take us through the rates at the moment, please?

Ms Cass: I am happy to. I will recap for you. You know that since 2009, when the DonateLife Network was established, there has been strong growth in the number of donors,

the rates of donation, transplant recipients and organs transplanted so the story to the end of 2014 does amount to a 53 per cent increase in the number of organ donors, a 38 per cent increase in the number of transplant recipients and a 39 per cent increase in the number of organs transplanted, which put into a population rate, at least for donation, is a 41 per cent increase in donation rates.

In February at the beginning of this year we talked about the fact that the 2014 outcomes were down compared to 2013 in terms of donation. They were on a par in terms of recipients and one per cent higher in the number of organs transplanted. The issue for 2015 was to ensure that there was intense effort to continue to reform donation practice at a jurisdictional level and at a hospital level.

The provisional outcomes to May 2015 are that there was a record 40 deceased donors in May in a year to date outcome of 158 deceased donors. Both January and May were records in terms of outcomes, but there was a disappointing outcome in April of 20 donors. What that means is that the monthly average so far for 2015 is 31.6 donors per month compared to the annual monthly average of last year, 2014, that was 31.5 donors per month. There is a slight increase at the moment in terms of monthly average.

In the last 12 months since June 2014 there has been five months with record donation outcomes. The most encouraging thing is what appears to be a turnaround in performance in New South Wales, which was one of the issues that we spent quite a bit of time discussing in February, because they have historically had low donation outcomes. In May, New South Wales had 17 deceased organ donors and approximately 55 organs for transplant, which basically means that New South Wales has shifted from what was a monthly average to April of about 7.2 donors to a new year to date monthly average of 9.2. That is encouraging. If that continues it means they will be more on a par with the outcomes that are being achieved in Victoria, for example, which has 10 donors per month to May 2015. They are the outcomes as at the end of May and obviously there is significant work in train to continue that momentum.

Senator McLUCAS: My opening question was possibly framed incorrectly, that there has been a slowing of rates. How would you characterise the 2014 figures?

Ms Cass: 2014 was a year which is actually not out of sync with international practice in donation reform. If you look at what has happened in Spain, Croatia and Portugal, there is year-on-year variation in terms of outcomes within a longer term trend of growth and in both Spain and Croatia, strong examples, they achieved strong outcomes in terms of donation over 10 years. Portugal is a good example of year-to-year variation, and in some instances dropped right back to its starting point and then regained momentum. It is a process of changing a whole system of end-of-life care and accountability and quality assurance practices in management of critical care and end-of-life care in the hospital system.

Senator McLUCAS: Do you count the potential donor population? Is there some measure of working out whether or not the coordinators are not being supported strongly enough, for example?

Dr Opdam: I am happy to give you some information about donor potential in Australia, which has certainly been an interest of mine for nearly two decades.

Senator McLUCAS: I did not know. It is not a dorothy dixer question.

Dr Opdam: Collecting data on deaths in Australia to ensure that we understand the potential donor pool and that we can learn where there is potential to change practice and increase donation rates is something that is being done nationally. We conducted the DonateLife audit of deaths in 72 hospitals in 2014. That audit revealed that last year there were only 500 patients who developed brain death and could be organ donors through that pathway. Note that the DonateLife audit captures nearly all brain dead donor potential in Australia in that it captured 96 per cent of that donor pool last year. We have a very good handle on which hospitals have the potential for donation. We review every death so that we understand if there are missed opportunities. Of the 500 potential brain dead donors last year, there was identification and approach to the family to request donation in 98 per cent of them. In 12 instances there was not a discussion with the family, and that was because, for example, the family did not accept brain death or the poor prognosis of their relative, or the treating staff considered the patient medically unsuitable or too old in three cases, or physiologically too unstable to be able to support to the point of organ donation in three cases or various other reasons, including no family contactable or families were threatening staff.

We have an excellent capacity to identify potential donors. Staff are approaching families and ensuring that there is a discussion about donation and that a decision about donation is made. In those 488 patients, there was a 59 per cent consent rate. Obviously in this pool of potential donors in Australia, which is the majority of potential donors, the biggest impact that we could make in gaining additional donors is to increase the consent rate. The total donor pool is larger than that number.

Senator McLUCAS: So the total donor pool is the total potential donor pool?

Dr Opdam: The total potential donor pool, sorry, is larger than that number. When we include potential donors who can donate through the circulatory death pathway—keeping in mind only about one per cent of people who die in hospitals die under the circumstances in which donation is feasible—the vast majority of them are through neurological determination of death—that is, they develop brain death. There is a small proportion, if it is deemed appropriate to cease life supporting treatment because of a poor prognosis and it is thought that they will die very soon after removal of life support and other factors also with respect to suitability, that could donate after cessation of the circulation—that is donation after circulatory death. Last year in Australia, when we added in that donor pool, we had about 700 potential organ donors in this country—

Senator McLUCAS: So brain death and circulatory death?

Dr Opdam: when we add the potential brain dead pool and the circulatory death pool. Patients donating after circulatory death contributed 28 per cent of actual donation cases—that was 107 of the 378 deceased donors. This is a potential area for growth. We cannot grow the brain dead donor pool. We do not want more people particularly dying with brain death. There is potential for the DCD donor pool to be under-recognised. It is a very challenging area because many of them do not actually die within the time period that permits donation to proceed, so there is far more effort and resource expended in terms of pursuing that particular donation case. About 50 per cent do not actually proceed to donation. With about 20 to 30 per cent, you have the whole process worked up, surgeons in the operating theatre but the person does not die. So, it is a lot more effort with lower return, but that is what we have to do if we want to increase the rates.

Senator McLUCAS: Does not die within 90 minutes?

Dr Opdam: Yes, that is correct. The other way we can expand the donor pool is through broadening medical suitability criteria. This is also something that we are looking at very closely. It requires close collaboration between the donation and transplantation sectors, and it also requires community support for this approach. Medical suitability criteria are forever broadening. With the shortage of organs and improved medical transplantation practice we can do more with organs from older donors and organs from individuals who have considerable previous health issues, or who may have some risk activity or some past disease that poses a small but above normal risk of some disease transmission. We are proceeding with those donors more and more, but we can further expand that donor pool. That is one of the reasons why countries like Spain have particularly higher donation rates. They have acceptance of using organs from these more marginal donors. We have undertaken some significant steps in furthering use of that donor pool in this country. One of them is developing a suitable framework to guide clinical practice. You may be aware that we now have draft NHMRC ethical guidelines for organ transplantation from deceased donors that have recently gone out for public consultation. We are also seeking to revamp our organ matching system in this country to have a more robust system that has greater sophistication in its ability to match like-for-like organs to recipients, which we currently do not have. That is a negative driver in the system that makes it difficult for organs from older donors, or those with some health issues, whereby the organ will not last as well as a standard criteria organ, but could still benefit many individuals above not receiving an organ at all. What we need is the capacity to match those organs with suitable recipients. We currently lack that. We have undertaken substantial steps towards developing an enhanced Australian organ matching system with that end in mind.

Senator McLUCAS: Thank you very much for that information. Ms Cass, in terms of the authority, what has been the impact of the proposed merger with the NBA on the operations internally in the authority? What sort of time has been allocated to preparing for a merger?

Ms Cass: There has been work across the NBA, Department of Health and the OTA in preparing for a merger. I have worked on the legislation on the implication in terms of staffing systems and readiness. I think that is essentially complete. We are all waiting to see what the timeframe might be for decision making and action.

Senator McLUCAS: Moving to the idea that, if the policy people in the department are doing work that is mirroring what is happening in agencies, do you expect there to be a reduction in staff in the department as a result of that approach?

Mr Bowles: Yes, I would, but not significant numbers. We do not have a lot of people dedicated to that.

Senator McLUCAS: There are not a lot of people in there.

Mr Bowles: We just want to have a look at the fact that we do not want to mirror anything that is happening already in either MBA or OTA.

Senator McLUCAS: How many people do you think work in the department who have responsibility for organ and tissue donation policy?

Mr Bowles: We would probably take the actual number on notice, but it would be in the handful sort of number.

Senator McLUCAS: I would not expect that that is the only work they do. Do they have other responsibilities as well?

Mr Bowles: That would be right. They would be working across different areas. We could take on notice the exact number, but you are talking maybe five, seven or eight, I do not know, something like that, and they would work on a range of different issues.

Senator McLUCAS: That is my understanding. Is the review that is being undertaken into the organ and tissue donation authority that is underway being managed by departmental officials?

Mr Bowles: Yes, that is correct. Are you talking about the review that was announced by the minister last week?

Senator McLUCAS: Yes.

Mr Bowles: Yes, it is managed by the department.

Senator McLUCAS: How long is it expected to run?

Mr Bowles: We are looking at a short, sharp review. We are looking at around eight weeks.

Senator McLUCAS: How was that review initiated?

Mr Bowles: I initiated the review and then had conversation with the minister about it. That is basically where it started.

Senator Nash: May I just round off a couple of points before you go on to the next question? Just to be clear, the department is not actually conducting the review.

Senator McLUCAS: No, that was my next question.

Senator Nash: Just to be clear for the *Hansard*. Also, it is not into the OTA; that is just part of the broader review that will look across states and territories, across the hospitals, LHNs, working with clinicians and other stakeholders. It might assist to know that the terms of reference are up on the website now. They will give you an indication of the breadth of the review.

Senator McLUCAS: When did they go up on the website?

Mr Bowles: Saturday.

Senator McLUCAS: My understanding is that the review will have a specific focus on the role of the Organ and Tissue Authority.

Mr Bowles: It obviously focuses on the Organ and Tissue Authority, but it looks at the broad issue of organ and tissue donation. It will look into the broader issues around that. We are not looking at something that is going to go forever. This is a short, sharp review over eight weeks, and it will inform how we progress from there.

Senator McLUCAS: I have not seen the terms of reference.

Mr Bowles: It went up on Saturday morning, I think.

Senator McLUCAS: Saturday morning? Who got up on Saturday morning to do that?

Mr Bowles: Saturday evening they went up on it.

Senator McLUCAS: Saturday evening?

Mr Bowles: I think they went up in the evening.

Senator McLUCAS: More reason why I have not seen them.

Mr Bowles: We work around the clock.

Senator McLUCAS: In preparation for Senate estimates?

Mr Bowles: No. I wish it was only before Senate estimates that we did this sort of stuff, but it is all the time.

Senator McLUCAS: How much will the review cost?

Mr Bowles: We are still finalising the contract arrangements for that. I do not think we have a final cost at this stage. No, we do not.

Senator McLUCAS: How was it that Ernst & Young were selected as the reviewers?

Mr Bowles: They were selected off a panel. We have a panel for reviews of this type. Ernst & Young have a background on the history and working both in the department and across many agencies in this sort of activity.

Senator McLUCAS: Did the department, the minister or the minister's office speak to any Ernst & Young directors or former directors prior to the announcement of the review?

Mr Bowles: I know I met with a group of people and I later found out one of whom was a former member of Ernst & Young, if that is what you are referring to. They were a member of the Share Life group. They were a former member of Ernst & Young.

Senator McLUCAS: Is that person a former director of Ernst & Young?

Mr Bowles: I do not know what their role was in Ernst & Young. I know they worked there. That is all I know.

Senator McLUCAS: Did you know that, Mr Bowles, prior to the appointment of Ernst & Young when you met with the Share Life people?

Mr Bowles: No, I did not.

Senator McLUCAS: Did you make the decision to appoint Ernst & Young?

Mr Bowles: The department made that decision. Mr Cormack and I had a conversation about it, yes.

Senator McLUCAS: Was that matter known to you at that time?

Mr Bowles: No. I knew the person from a previous review in a previous organisation. I did not know that the person actually worked for Ernst & Young at all.

Senator McLUCAS: Worked for or was a director of?

Mr Bowles: Director in the Ernst & Young language would be they are not a partner, they are a worker.

Senator McLUCAS: They are not a stenographer?

Mr Bowles: Sorry?

Senator McLUCAS: They are not at the level of a stenographer?

Mr Bowles: No, but they are not a director in the context of a company director; let me make that very clear. So they are not a partner; they are not a company director. A director is like an executive-level person in my department, for instance, who works on particular projects. That is assuming that is what that person was. I do not know exactly what they were.

Senator McLUCAS: Subsequent to your finding out that there is a link between Ernst & Young and Share Life, have you had reason to contemplate whether Ernst & Young is the right entity to conduct the review?

Mr Bowles: Mr Cormack will answer that. We have actually made inquiries, obviously, around this issue once we got knowledge of it. Mr Cormack can keep going with that.

Mr Cormack: We certainly have discussed the issue with Ernst & Young. They have a very well established set of protocols that they follow on any assignment, not just this one, to ascertain any specific declarations of any potential conflicts of interest. We have not yet signed up a contract with them. We are in the final stages of working that through. But the extent to which that has any influence on the contract is a matter that will be worked through. There are just a couple of points to note in the specifics here. The review actually has nothing to do with a director of Share Life. The review is actually about the overall program. I am advised that the person to whom you are referring is no longer an employee of Ernst & Young and has not been since I think December last year. I would also like to clarify very specifically that at no time did the person or the representatives of Share Life that approached the department on a range of matters in any way specifically seek such a review, let alone did they seek obviously for Ernst & Young to be involved in that. I think we just need to be very clear here. We are just going through a normal process that we would go through with consultants to ensure that they comply with our requirements.

Senator McLUCAS: So, Mr Bowles and Mr Cormack, you have both met together with the Share Life group?

Mr Bowles: That is correct.

Senator McLUCAS: Minister, have you also met separately with the Share Life group?

Senator Nash: I have, indeed, and could I also just add, as you asked the question, that neither my office nor I met with Ernst & Young. In relation to Share Life, yes.

Senator McLUCAS: On how many occasions?

Senator Nash: From memory, two, but I will need to check the record on that.

Senator McLUCAS: Was the issue of a review contemplated in the meetings that you had with Share Life?

Senator Nash: Not that I can recall. It might help to just add some context around how we got to this point. I am well aware there has been a little emotion in response to this review going ahead.

Senator McLUCAS: It is in the public arena.

Senator Nash: Absolutely.

Senator McLUCAS: I think we need to get some real clarity about this.

Senator Nash: That is why I think it might help to clarify the situation a little, following on from the department's recommendation to do the review, which I agreed with. Contrary to some commentary, I continue to retain my backbone. The thing around this is that it is very simply a common sense review into whether or not we can do better in this area. We arrived at this point from my being aware and the department being aware that there was a range of views about how well Australia was going when it comes to organ donation and transplant from a number of stakeholders, ranging from very good to could do better. It just seemed

prudent and common sense—and I do have to say before I go on that I have worked with the OTA very well and we have done a lot over the time I have been in this portfolio. I certainly have been to a number of events and met with people and families who were involved in this issue. It became quite clear that, given the diversity of views around this, it would simply be common sense to have a review to look into these issues and see exactly, from the point of view of a review that the secretary was just saying is not going to be a long review—it will be a short review—to determine the facts and the statistics and the figures around this issue. That seems to me just to be simply common sense. I hope the people that have been interested in this announcement and have a view either way are listening very closely. It is a very broad-ranging review that will look, as I say, at a number of areas. The terms of reference are now available. Rather than read those, because they are quite lengthy, I would direct people to look at those.

Senator REYNOLDS: My questions will not take long, but they are on the same topic. Minister, can you explain a bit further about why the government commissioned this review? Was it on the advice of the department or did you have other concerns?

Senator Nash: It was on advice from the department after discussions with the department around this. I think I have been reasonably clear that there were a number of views from different stakeholders about the veracity of some of the statistics. It just seemed to me sensible and prudent, as the department obviously did as well, to have a review to look at this. The point about the review—and this is something that has become very clear from my talking to a number of stakeholders—is that everybody wants to see organ donation rates rise. Organ donations save lives. That is the point we are starting at. As the minister responsible, it seems very sensible to determine whether or not we can do better. Certainly there has been some improvement. I have been on record as saying that. Again, I have worked very closely with the OTA, but I say again it just seems absolute common sense to do the work and see if we can do better.

Senator REYNOLDS: From some of the feedback that you have received, where are some of the conflicting opinions or attitudes or issues out there?

Senator Nash: Without wanting to identify particular individuals, it is across a range of the sectors. It is from organisations, from clinicians, from community members—so a range.

Senator REYNOLDS: Is it more on the basis of that causation or about how to fix it with new measures or a little bit of both?

Senator Nash: I think there are differing views around that, and that is one of the reasons that I think it is just prudent to have a review and look and determine what are the actual facts.

Senator REYNOLDS: Did you have any specific concerns about the way the program itself was being run?

Senator Nash: I have certainly worked very closely with the OTA and have been very appreciative of the relationship I have had with the OTA. My concern is around determining whether or not we have the facts right. No so much about any in the sector whether or not the performance is appropriate, but whether the facts are right, and that the things we are doing are giving us the outcome we want.

Senator REYNOLDS: This review was announced after the budget; is that correct?

Mr Bowles: Yes, it was.

Senator REYNOLDS: I think there has been a bit of speculation about the timing. Can you perhaps tell us a bit more about the timing of this?

Senator Nash: I might get the secretary to add to this, but there was a discussion and a recommendation from the department.

Mr Bowles: Yes, basically there is no relationship between the budget and this. A whole lot of things just happened to coincide, I suppose. I think the minister announced this last week. I cannot remember the exact timing now. Yes, it is totally coincidental to any budget related issues.

Senator REYNOLDS: Nothing to do with the budget at all. Okay. Thank you. Now coming to the budget, I think it was announced that $10.2 million would be spent over the next two years. Can you explain a little further about how that money will be used and what the hoped linkage is between that and increased donations?

Mr Bowles: That is subject to a conversation that I am currently having with both ministers. I would not want to pre-empt that at this particular point.

Senator REYNOLDS: So no decision has been made yet on how best to use it?

Mr Bowles: Yes, subject to the conversations I am having with both ministers.

Senator Nash: If I can assist, we should be making some announcements very shortly.

Senator REYNOLDS: I apologise in advance if somebody has already canvassed this issue, because unfortunately I missed the beginning, but did you talk about the new Australian organ matching system?

Mr Bowles: Only in a broad sense. It is an issue that I am having conversations with both ministers about, and the minister just referred to.

Senator REYNOLDS: If it has not been finalised yet, are you able to perhaps give the committee a bit of background on what it is designed to do and why it is being established?

Mr Bowles: Probably not at this stage, if you do not mind. There is still a little bit of work to be done on some of these things.

Senator REYNOLDS: Did you talk before about online registration?

Mr Bowles: No.

Senator REYNOLDS: One of the things that has been discussed is the possibility for potential donors to do online donations. Is that designed to make it easier?

Mr Bowles: Again, the same sort of issue.

Senator REYNOLDS: Okay.

Senator Nash: I can add a bit of context. There is room for improvement, and certainly the current system does appear to be a bit cumbersome.

Senator REYNOLDS: Are you looking to streamline it and make it easier and make it more effective?

Senator Nash: We all hope for that outcome.

Senator DI NATALE: I will not be too long. Just to go back to the donation rates—2014 was a disappointing year but, Ms Cass, you were effectively saying it is probably an outlier

that you expect to see some year-to-year variation? Would that be an effective summary of what you have said?

Ms Cass: I think that is correct. If you look at the growth trajectory internationally, that is certainly the case.

Senator DI NATALE: My concern is that we are halfway through 2015 and we have seen no change to donation rates. So, 2014 is an outlier. We will wear one bad year, but we are halfway through 2015 and we have not seen any change. At what point do you start to worry that it is not an outlier and that in fact you are starting to see a flat lining of donation rates?

Ms Cass: We look at performance on a monthly basis at the hospital level. Our work every month is basically dealing with states and territories and agencies to identify those hospitals where it appears that there is room for improvement in terms of request, consent and, to a lesser extent, donor management to achieve conversion or actual donors. This is a process of continual quality improvement. That is the model that Spain stresses and that Croatia also stresses. This is about a process of continual observation and intervention. We will have the capacity to reinforce that as a result of budget announcements to be made.

Senator DI NATALE: I understand the process. I suppose all I am suggesting to you is, if 2014 is an outlier, and we are halfway through 2015 we are still seeing no change. Given that you are going through this continual quality improvement process, at what point do you start to worry that some of the things that we are doing need to change; that it is not actually working? That is my only concern. In the first few years we saw a modest increase, but for a year and half now we have seen no increase. In fact, New South Wales went backwards. At what point do you ask yourself the question, 'Maybe we need to review what we are doing'?

Ms Cass: Firstly, let me set a couple of those things in context. The growth that has been achieved by Australia in the first five years of implementation is actually commensurate with that achieved in Spain and the United Kingdom. Portugal, as an example, actually in its first five years achieved a zero per cent growth rate because it increased and then fell back to its starting point. In Spain they achieved a 52 per cent increase in the first five years and in Australia and the UK it is 41 per cent growth in their donation rates. We have achieved rates which are comparable with that experienced internationally and all of the international literature and models say this is about the long haul. It is a 10-year process of change in end of life care. We have worked closely with colleagues in Spain, Croatia and Portugal to understand what they have done. We have produced fact sheets together so that we understand exactly the work that they have implemented and we are implementing the reform model that has been illustrated as being successful internationally.

Senator DI NATALE: Let me ask you about 2015. Did you say there was an increase from 7.2 to 9.2 in New South Wales?

Ms Cass: Donors per month average; that is correct.

Senator DI NATALE: Obviously if the numbers have not changed in 2015 then what states have the decreases occurred in?

Ms Cass: I would have to pull that out for you. There has been an increase in terms of their monthly average to May.

Senator DI NATALE: It is 0.1. It is effectively the same. It is probably a rounding error. If we assume that it is the same and there has been an increase from 7.2 to 9.2 in New South

Wales then there has obviously been a commensurate decrease in other states. I am just asking where those other states are.

Ms Cass: I was talking about the monthly average in 2014 compared to the monthly average year to date in 2015. I will go and unpack it. We are working on electronic donor record data at the moment, because I am waiting for the ANZOD data to actually be published at the end of this week.

Senator DI NATALE: Do you have a sense of what states might have gone backwards?

Ms Cass: I do not at the moment. As soon as I have the data I am very happy to provide the information to you.

Senator DI NATALE: This question of the donor pool is a little curious from my perspective. Obviously as you are all aware there are a number of advocates in this space who have particular views about what should and should not happen. I think very early on I asked about some protocols around circulatory death and brain death. I am quite happy to go through the *Hansard* evidence and read it out to you but I was told, 'We've adopted the best protocols. We can't touch them because in other jurisdictions there are differences around medical practices and culture and so on.' Now I am hearing evidence that we are looking at revising some of those and expanding the donor pool. I am not really sure I understand whether we have decided that we might have been a bit too cautious and now we need to revise existing protocols.

Dr Opdam: I am not sure what you mean by 'protocols'. We are talking here about identifying a person who has a terminal illness, who is on life support in the intensive care unit, and people identifying that person as someone who can donate. That is a complex judgment. One of the things people are trying to judge is how long a person will breathe for when they are removed from a mechanical ventilator. There have been studies looking at how one might predict that and there is no good way of doing it. There is no particular objective physiological criteria that you can hang your hat on. In fact, an experienced clinician making a best guess judgment at the bedside is probably the best thing. Sometimes you get it wrong. You think the person will not die on a timeframe and they do and, in fact, had you gone through the process and set everything up for donation you may have had a donor. Often we set up the process and the person does not die in the timeframe. There are opportunities for misdonation. How many of these such cases should one proceed with when you are uncertain of the outcome?

Senator DI NATALE: You need to answer that question. What I am saying to you is that we knew this five years ago. It is not like the evidence around this has changed in five years. What I am asking is: are we looking at expanding the donor pool on the basis of a concern about donation rates and potentially looking at another group of people that perhaps five years ago we were not looking at?

Ms Cass: Can I just go to that point. We work with the Transplantation Society of Australia and New Zealand on the clinical protocols for donor suitability and transplantation suitability. Those guidelines change frequently. None of this is set in stone. There are changes in clinical practice in transplantation such as the introduction of DCD heart transplantation, which has completely changed in terms of DCD donors, whether they are eligible to be heart donors or not. There has been work done on the age cuts-offs for liver donation and for lung

donation and what are the criteria for donor suitability. That is about changing expectations and understandings of suitability in clinical practice. We work with TSANZ on a quarterly basis to review those documents and they are updated. None of this is fixed.

We have now reached a point where there has been significant discussion with TSANZ in looking at the donor aged profile in Australia and comparing that to the donor aged profile in Spain. We know that in Spain 52 per cent of their donors are 60 years and older and that around 30 per cent of their donors are 70 years and older. In Australia last year just 26 per cent of our donors were older than 60 years. Now they have a much greater reliance upon donors that we would not proceed with in Australia to the point where 30 per cent of their kidneys are transplanted and 40 per cent of their kidneys are transplanted from donors who are 60 years and over.

The discussion that we are having now is what is the right donor age profile suitability for Australia. We have had extensive discussions with the Transplant Liaison Reference Group and with TSANZ about those very issues and in fact one of the greatest explanators for this is that in Spain, right from the very start, they had an explicit matching criteria which allowed old for old, disregarding mismatch which means that an old donor could basically be matched with an older recipient and the fact that there might be a tissue typing or an antibody profile mismatch was not taken into account. That allowed them to basically proceed with much older donors and transplant from those donors. That is exactly the sort of discussion we need to have and the facility to allow that sort of risk based and age based matching in Australia.

Senator DI NATALE: I think it is the right discussion. I am just interested in whether we are having this now on the back of the review? Is this something we have been doing for some time?

Ms Cass: It is the work that has been in train for a solid period of time.

Senator DI NATALE: Thank you.

Senator LEYONHJELM: Which Commonwealth law prevents the sale of blood and organs?

Ms Cass: The state and territory Human Tissue Act.

Senator LEYONHJELM: So, it is only a state law and not a Commonwealth law?

Ms Cass: That is correct.

Senator LEYONHJELM: Do they prohibit any sort of payment to providers of blood and organs?

Ms Cass: I would have to check. I think they prevent valuable consideration.

Senator LEYONHJELM: Is there anything akin to a market for blood or organs within Australian health institutions?

Ms Cass: Not in Australia, no. It would be acted upon in a state if it were to occur.

Senator LEYONHJELM: So, would it be shut down if it occurred?

Ms Cass: I believe so.

Senator LEYONHJELM: By your department?

Ms Cass: No, by the state.

Senator LEYONHJELM: Does your department have any evidence regarding the effect on blood and organ supply of allowing payments?

Mr Cormack: That is a policy question. We would like to take that one on notice. There are some international treaty obligations to consider there. We will take that on notice.

Senator LEYONHJELM: Just for clarification, I am not seeking your comment on policy. I am aware of the situation here. What I am interested in is any evidence you have in relation to the effect on blood and organ supply of allowing payments.

Mr Cormack: We will take that on notice.

Senator LEYONHJELM: Thank you.

Senator McLUCAS: I was having a conversation with you, Minister, about the process base that you undertook to establish the review. I understand that the ABC reported that there was going to be a review on 27 May and then you announced the review on 29 May. Is that correct?

Senator Nash: I do not have that those dates in my head.

Mr Bowles: I think it was the 27th.

Senator McLUCAS: I do not have a copy of your press release. A portion of it is dated the 29th.

Mr Bowles: I think originally it was on the night of the 26th or the day of the 27th.

Senator Nash: I will take it on notice and check it for you so we get you the right date.

Senator McLUCAS: Who did you talk to from the point where the department suggested that a review—and if I quote the first term of reference—'how effectively the program has been led by the AOTDTA'? Who did you talk to from the point that you received the advice that the department was suggesting you undertake or approve the review to be undertaken and then you announced that review? Which sectors of the organ and tissue donation community did you talk to?

Senator Nash: Firstly, just to clarify, I noted the review and the recommendation that came to me that it go ahead. I am sorry, what did you say, did I talk to in—

Senator McLUCAS: Between the time that you received the release—

Senator Nash: I got that bit. I just did not hear the last bit of your question.

Senator McLUCAS: Who did you talk to between the time that you received the brief and then you agreed and put out a press release? Did you ring the authority? Did you talk to Share Life? Did you talk to the Transplant Coordinators Association, the Australia and New Zealand Intensive Care Society and the Transplantation Society? Who did you confirm with that this was a good course of action?

Senator Nash: That is what I was trying to explain before. I noted the recommendation from the department and it went back to the department. I did not speak to any of those people.

Senator McLUCAS: No-one?

Senator Nash: No.

Senator McLUCAS: On what basis did you agree that this was an appropriate course of action?

Senator Nash: On the basis of the advice from the department and—

Senator McLUCAS: You do not—

Senator Nash: Let me finish, and the previous concerns that had been raised with me prior to the advice coming from the department.

Senator McLUCAS: From whom were those concerns raised?

Senator Nash: They were raised from a range of stakeholders across the sector including community, individuals and stakeholders across the sector.

Senator McLUCAS: Could you be clearer with the committee about who?

Senator Nash: I am very happy to take that on notice in terms of specific individuals or groups, but to be clear, it was across the sector, so stakeholder organisations, clinicians and community individuals that had an interest and a view. I am happy to take the detail on that for you on notice.

Senator McLUCAS: Do you have an advisory council? Is there an advisory council?

Senator Nash: The OTA has an advisory council, if that is what you are asking.

Senator McLUCAS: Did you talk with any of the members of the advisory council?

Senator Nash: No, I did not.

Senator McLUCAS: None?

Senator Nash: I just clearly said that.

Senator McLUCAS: Have you had meetings with the advisory council?

Senator Nash: No.

Senator McLUCAS: Since you have become a minister?

Senator Nash: No, not the advisory council.

Senator McLUCAS: You did not think that was a worthy thing to do?

Senator Nash: I work very closely with the OTA. The advisory council advises the OTA. That is the process.

Senator McLUCAS: Can you provide on notice a list of organisations from the organ donation sector that you have met with this calendar year?

Senator Nash: The calendar year? Why just this calendar year?

Senator McLUCAS: Because it seems that it is in this period of the calendar year where this issue has emerged. Is it reasonable to say that?

Senator Nash: Certainly, although I would say that since I have been in this position and been responsible in this area it has been from the time I took over as minister so my deliberations around this have been informed over a period of time, but I am very happy to take that on notice for you.

Senator McLUCAS: You have taken on notice the number of times you have met with Share Life?

Senator Nash: Indeed.

Senator McLUCAS: That includes formal meetings and also telephone calls.

Senator Nash: Certainly.

Senator McLUCAS: Members and collectively.

Senator Nash: Certainly.

Senator McLUCAS: Could you also do the same for, let us say, Transplant Australia?

Senator Nash: Certainly.

Senator McLUCAS: What was the process that the terms of reference were developed?

Mr Cormack: The terms of reference were developed by the department.

Senator McLUCAS: Were they signed off by the minister?

Mr Cormack: We advised the minister of the terms of reference and those terms of reference were accepted.

Senator McLUCAS: They did not need to be approved by the minister?

Mr Cormack: The review is being undertaken by the department. We provided advice to the minister recommending that course of action and the terms of reference were determined by the department.

Senator McLUCAS: Were there any amendments made in the minister's office to the terms of reference?

Mr Cormack: I am not aware of any amendments.

Senator McLUCAS: You can tell us if there were?

Mr Cormack: Yes, but I am certainly not aware of any.

Senator McLUCAS: I might leave that issue there and put any other questions on notice. Ms Cass, this estimates is before 30 June. I understand from previous evidence that when the merger goes ahead there will be one CEO of the merged authority. If it does transpire that you do not come back to see us can I say, on the record, that our committee has been very grateful for the excellent advice that you and your authority have given us over many years. I am personally very indebted to you for the work you have done over many years and I would like to pass on our thanks to you and to the authority, but in saying that we would very much like to see you back as the head of the NBA.

CHAIR: Is that all from this outcome?

Senator McLUCAS: No. That is all for the Organ and Tissue.

CHAIR: I remind you—and we have discussed this—that we are now one hour over time.

Senator McLUCAS: We made it up last night. Have faith in me.

CHAIR: I will just point out that anything we did last night does not affect today's schedule. We did have an agreement to try to stick to time. I cannot force the closure of an outcome, but I would remind senators of the agreement of this committee.

Senator McLUCAS: Thank you. I would like to go to the National Blood Authority and the merger.

Senator MOORE: I have some questions on the National Blood Authority. One is in the area of haemophilia treatment and the other one is around the proposed merger.

Mr Bowles: Do you want to do the merger?

Senator MOORE: Yes. We will do the merger first.

Mr Bowles: It is what I basically said before, because it is the merger between the ATA and the NBA. There is no real difference between what I said before and this one, except you want to ask them about what activity they have done.

Senator McLUCAS: In terms of the costs for the merger.

Mr Bowles: Yes. I will take that on notice the same as I did with the other one.

Senator McLUCAS: Will we start on 1 July?

Mr Bowles: That is the same.

Senator McLUCAS: See above. Any external consultants?

Mr Bowles: It is the same answer there. It is all one issue in the department.

Senator McLUCAS: And to the NBA can you quantify the costs internally and externally, if appropriate, in preparation for the merger? You could take that on notice, Mr McJames. That will do in terms of the merger.

Senator MOORE: What service does the National Blood Authority run for Australians living with a haemophilia?

Mr McJames: Our primary service is the provision of clotting factors to support haemophiliacs but in addition we support the peak clinical body, the clinicians, and we also provide an IT system called the Australian Bleeding Disorders Registry and we liaise closely in terms of education with the patient advocacy group.

Senator MOORE: Do you provide any products for haemophiliacs?

Mr McJames: We do.

Senator MOORE: What are they?

Mr McJames: There is a range of clotting factors. Broadly we group people that suffer from deficiencies in clotting factors as having bleeding disorders. Of that there are two main haemophiliac groups; those who suffer from haemophilia A and haemophilia B. For each of those main groups the primary products we provide are a recombinant factor VIII and a recombinant factor IX.

Senator MOORE: How are the services accessed?

Mr McJames: Generally through state based haemophilia treatment centres but the actual distribution of product can be direct to home.

Senator MOORE: Delivered to the home?

Mr McJames: Delivered to the home.

Senator MOORE: Do the patients access these products through the pharmaceutical scheme?

Mr McJames: No. They access them through the national blood arrangements.

Senator MOORE: Are any haemophilia therapeutic products available on the PBS or are they all managed through that NBA?

Mr McJames: They are all managed under the national blood arrangements.

Senator MOORE: And how are they funded?

Mr McJames: They are funded on an arrangement under the national blood arrangements. The Commonwealth provides funding of 60 per cent and states and territories provide 37 per cent.

Senator MOORE: Has that been the standing ratio for a number of years?

Mr McJames: Since 2003 and the establishment of the national blood arrangements.

Senator MOORE: Has it been reviewed in that time?

Mr McJames: It has had. I would have to check but I think in approximately 2006 there was a review of how the arrangements were going.

Senator MOORE: How frequently does the NBA revisit its contracts with providers for the haemophilia products?

Mr McJames: We let contracts on the basis of approximately three years with 2 one-year extension options. That is our standard model, but we can vary it depending on what the products are.

Senator MOORE: What would the longest period be?

Mr McJames: Five years. We would let the primary contract and then we may take up 2 one-year options.

Senator MOORE: I understand there are some newer longer lasting treatments that have been listed on the Australian Register of Therapeutic Goods. Is that correct?

Mr McJames: There is one new long acting product listed, but there are certainly more in development internationally.

Senator MOORE: What is the name of the one that is listed? If you do not know then do not worry. I can find it.

Mr McJames: Okay.

Senator MOORE: When and how would the authority next consider using them for Australian patients and what does the process look like when the NBA adopts a new option for treatment?

Mr McJames: I will talk about the long acting products. The key issue is how different is it to the products that are currently listed and authorised for supply. We would go through a process that would resemble an AMSAC process so it would be looking at how different or how similar that product is to the ones we already supply. If they are largely similar we would seek approval from all governments to include those products on our national supply list. If they are different then we would have to go through an AMSAC process for them to be added as a separate category on the national supply list.

Senator MOORE: At that stage do you have to go through the AMSAC itself and not your internal AMSAC-type arrangement?

Mr McJames: The initial part of the process would be a simplified process run by the NBA but if it was complex then we would end up referring it to AMSAC.

Senator MOORE: Which is to go back into the system to have a look at all the strange things. Have you had to do that very often in terms of the range of products you offer?

Mr McJames: No.

Senator MOORE: I would not have thought so. Has the biggest innovation recently been the long-lasting treatments?

Mr McJames: In the haemophilia space, yes.

Senator MOORE: Thank you.

CHAIR: Is that all?

Senator McLUCAS: I think we have finished with blood.

Therapeutic Goods Administration

[15:01]

CHAIR: Which other part of outcome 7 do people want?

Senator McLUCAS: TGA. Professor, yesterday we covered a lot of the Corporate and Legal Services questions. I am going to try and identify in this list of questions whether there are some that were not covered yesterday. Can you advise whether the TGA's Corporate and Legal Services provide any specialist functions that are particular to the TGA? Are there any skills that your staff have that could not be identified in the department or any other area?

Prof. Skerritt: They certainly do. Yesterday I gave a figure of approximately 70 staff who are currently in a reporting line through to me through my first assistant secretary within the TGA who have specialised IT skills and specialised regulatory legal skills, for example. As the secretary indicated, those staff are not losing their jobs. Their reporting lines change so those specialist legal skills, detailed knowledge of our act and so on will continue to take place except their reporting line will be through to the department's general counsel.

Senator McLUCAS: Are you expecting that there will be any redundancies as a part of the measure?

Prof. Skerritt: As a?

Senator McLUCAS: I am sorry but I forget the language.

Mr Bowles: I think I went through this with you yesterday or maybe it was Senator Moore.

Senator McLUCAS: Are you suggesting I should listen hard?

Mr Bowles: No, I did not mean that at all. Basically the corporate folk from TGA, which are now part of the department but where we are going to merge them in with the broader departmental corporate services. I think over time you will see a reduction, but I do not see a significant reduction in the short term. This is where I said yesterday that we have almost hit our numbers for 2015-16, so I do not see any great changes for the next little while.

Senator McLUCAS: How much is currently spent on external legal counsel by the TGA?

Prof. Skerritt: That really depends on whether there are Federal Court or other issues running at the moment. We access a limited number of firms for legal advice. In the current financial year, in the period to 30 April, we spent $336,000 on external legal advice. Last financial year and the full financial year 2013-14 we spent $517,000. It is usually, for example, if you are retaining an SC to appear with you on a particular case, or a QC as it used to be, or for specialist advice that we seek external advice but the majority of legal advice is internal.

Senator McLUCAS: Do you have capacity internally?

Prof. Skerritt: Yes, both. With the facilities being combined we will have a larger pool of lawyers from which we can draw from.

Senator MOORE: I will take you back to your evidence yesterday. You said that you had 70 specialists and IT. How many are within the legal department?

Prof. Skerritt: What I said yesterday, and I should just clarify it in case there is any confusion, is that within our specialist IT branch and our specialist legal branch the number of staff who are moving to different reporting lines is about 70. It is actually a little bit under 70 if you look at the FTE basis.

Senator MOORE: I did not refine that yesterday to lawyers and IT.

Prof. Skerritt: Let us do that. I think it is number 7. Our current legal branch has 17 full-time equivalent staff. That includes support staff as well as lawyers.

Senator MOORE: Mr Bowles, how many are in the mainstream department's legal branch? You can take that on notice.

Mr Bowles: It is a few more than 17.

Senator MOORE: So, you are bringing those through together?

Mr Bowles: Yes.

Senator MOORE: We did not ask that yesterday. Thank you.

Senator McLUCAS: The PBS shows that the department's funding will not increase over the next four years. If you do not apply CPI that is an effective cut for the department's appropriation to the TGA. What effect do you think that will have on your operations?

Prof. Skerritt: The department's appropriation to TGA is a very modest one indeed and effectively covers the drug control section and the medicine scheduling secretariat. The overwhelming portion of TGA's budget comes from industry based cost recovery.

Senator McLUCAS: I understand that, but the departmental freeze on indexation will have an impact.

Prof. Skerritt: There was a significant reduction to our appropriation funding this coming financial year, but the main thing determining that was, firstly, that our funding for the partnership with New Zealand had come through in this current financial year rather than the next financial year. Secondly, not so much of a departmental allocation to TGA but in terms of capital expenditure again from our reserves. We are a fair way through an updated business improvement program, which is the way we interact with companies and sponsors. They were the main factors that determined a projected decrease in TGA's overall budget next year rather than any indexation or CPI based freeze.

Senator McLUCAS: The number of international visits is also going down.

Prof. Skerritt: The total number of international visits by TGA is really categorised in two parts. Firstly, it is our GMP inspections. Increasingly we are using GMP clearances where we have information from a reputable regulator who has done a recent inspection. However, we will continue to need to do a number of face-to-face in-person inspections of GMP facilities.

The other component of our international travel actually relates to our work in international regulatory collaboration and harmonisation. That is very dependent on global diaries and global schedules. For example, in the coming financial year the WHO Conference of Drug Regulatory Authorities does not meet. It only meets in even numbered years. A lot of those things are determined by global cycles, but we are continuing a strong program and a growing program of international regulatory collaboration.

Senator McLUCAS: Of those two types of international visits, which—although you cannot really answer that question because the second lot are variable.

Prof. Skerritt: They are both variable because, of course, we do GMP inspections on demand from a company that wants to get a product onto the Australian market or when their current inspection period might reach that three or four years and there needs to be a reinspection.

Senator McLUCAS: This is a different issue, but once again still with the TGA. Could you remind the committee about the low value turnover exemption scheme?

Prof. Skerritt: Certainly. The low value turnover scheme is being replaced with the annual charge exemption scheme or the ACE scheme. The reason for the replacement of the scheme is the old scheme was tremendously unpopular. I guess you could call it a masterpiece in the creation of red tape. It required companies large and small, and it was a particular burden on small and medium sized enterprises, to have to do a detailed return of their turnover for each and every product that they had that was under a limit of 15 times the annual charge. I should add that following advice from the National Audit Office they could not even submit this return themselves, even if they were a medium sized company that employed a couple of accountants. They had to pay an external accountant to go and submit and certify that return. They also had to make an application for exemption at $155 per product. You can imagine that starts to add up with large numbers of products.

It was a very cumbersome scheme and highly unpopular across the overwhelming majority of industry and especially small and medium sized industries. We have replaced that, starting in July, with another scheme which is essentially an exemption. It is a zero turnover scheme. Under that scheme no application fee is required for products. Products will be automatically exempted until the turnover continues. You will not need an accountant and it will be done through online self-service.

For products that are low in turnover but are still important on a public health basis, if it can be shown that they would otherwise not be financially viable, you can apply for an exemption and one of our clinicians will look at that and say, 'Yes, this is important from a public health basis.'

Senator McLUCAS: The Australian dental industry is one group that is affected by the change. What other organisations?

Prof. Skerritt: All of our sponsors are affected. The vast majority of medical devices are represented by other groups such as MTAA and AusBiotech and, of course, medicines; whether or not they are represented by Medicines Australia, with the over-the-counter medicines, complementary medicines or the generic medicines industry. This affects all of our products.

Senator McLUCAS: In your view, what is the response from industry to the abolition of the—

Prof. Skerritt: There has been overwhelming and strong support for it. The Australian Dental Industry Association wrote to us about five particular companies and asked us to run the figures. When we ran the figures those five particular companies that they expressed concerns about indicated that they would be between $1,000 and $14,900 worse off if none of their products received the public health exemption—that is an 'if'. We do not know because what we are expecting is that a number of products will either receive a public health exemption or they may say, 'We're selling two of these and there's lots of other companies in the market.' They may make a decision to take a product off the market. The other thing that has been done for medical devices is a five per cent decrease in the base charges for class 2 devices and above.

What we have undertaken to do, because this scheme is actually costing TGA $2.4 million this financial year, is we have decreased our charges almost across-the-board. For example, for a generic chemical medicine, of which there are many other copies on the market and meets other criteria, there is a 23 per cent reduction in charges. I mentioned a five per cent reduction in base charges.

We will monitor the overall impact of this scheme. We will monitor how it goes after the first year. We need to do that every year in the context of going to government for approval of our annual fees and charges. That ledger will be open to all industry associations and I imagine, if there are particular industry sectors that, for unexpected reasons, have been very seriously affected by this, that is a discussion that we will have with the minister in the context of discussing what fees we would set for next year.

CHAIR: I will have to go to some other senators. If there are further questions I will come to you, Senator McLucas.

Senator McLUCAS: Can I have one question to finish?

CHAIR: Yes, a very quick one to finish and then I will go to Senator Xenophon and Senator Ruston.

Senator McLUCAS: So, full cost recovery for these groups will not be applied because you are saying that there is a cost of $2.4 million?

Prof. Skerritt: No. It is full cost recovery. We believe that we, in that sense, are able to become effective and more efficient. Not only does the current scheme that we are about to replace create a lot of red tape and paper shuffling for companies at the moment but it also creates a lot of checking, paper shuffling and red tape for us. We believe that there can be efficiencies gained for us and also for the regulated industry without any change to the risk profile. That is why we have modelled the $2.4 million reduction in charges.

Senator McLUCAS: So, it is a reduction in fees. I misunderstood.

Prof. Skerritt: It is a reduction to our base charge.

Senator McLUCAS: I understand that. Thank you.

Senator XENOPHON: In response to the question I placed on notice in October last year, SQ14-001248, the TGA stated that the Australian Orthopaedics Association National Joint Replacement Registry reports a low rate of revision for the Birmingham Hip Resurfacing

device, the BHR, so it remains available as a surgical option in Australia. I know, however, that the AOANJRR annual report in 2012 identified the BHR as having a higher than expected revision rate—that is at pages 171, 172 and 173—and that it has been re-identified as such in both the 2013 and 2014 reports. It was noted in the 2012 annual report at page 95 that the BHR had a cumulative per cent revision at 11 years of 7.1 per cent while the metal on metal total conventional hip arthroscopy report published by the journal in 2014 identifies a revision rate of 12.1 per cent after 10 years. How does the TGA explain these seemingly contradictory statements?

Prof. Skerritt: I will call on Dr Kelly to describe the detail. The information that I have on the data from the AOANJRR on the Birmingham hip replacement is that overall it does not have a revision rate higher than expected. I would also flag that it has not been withdrawn for use in any jurisdiction. As you aware from your earlier question, there has been advice against it through an update of the instructions for use—

Senator XENOPHON: I am happy for you to take this further on notice. I have set out some figures. I have set out the reports. On the face of it, there does seem to be a contradiction between what the TGA has advised and what the journal is reporting.

Dr Kelly: We will take those on notice with your figures. The figures we quote are also from the same source, the joint registry data. I am just wondering whether there is some confusion. There are a number of variants for the Birmingham hip device and I am just wondering whether we are talking about the same particular device.

Senator XENOPHON: And if you could explain that on any answer on notice. I will just continue. The TGA would be familiar with the metal on metal total conventional hip arthroscopy report by the AOANJRR from 2014 which outlines a decline in use and higher revision rates for metal on metal devices. Why is the TGA not placing further restrictions on the use of these devices or withdrawing them completely from the market?

Dr Kelly: I think we have explained this previously. The best advice we have is from the orthopaedic surgeons who analyse the same set of data that you are referring to. We present the information to them. We present the global information for the same types of devices collected across different registries around the world. Their advice remains that a blanket ban on metal on metal hips is not appropriate. They are very suitable for some patients.

Senator XENOPHON: Overall is there a higher rate of revision and complication?

Dr Kelly: Again, it depends on which type of device. There are resurfacing devices and there are total hip replacement devices.

Senator XENOPHON: If you could provide some further details. Finally, has the TGA learned from the lessons of the ASR and are you more cautious about these devices? There are literally thousands of devices approved for use in Australia. Should the TGA be more prescriptive about those approved for use? We have private health funds talking about the money that they fork out which causes increases in premiums because of the rates of revision. It has been a common complaint from private health insurers as well.

Dr Kelly: Hip replacement remains one of the most cost-effective operations in the health system. It is getting the balance right between the safety and the patient benefits. We, following the ASR and through some other factors, reclassified all hip joints so that they now have to go through a higher level of—

Senator XENOPHON: I would be very grateful if you could take on notice the complaints made by private health insurers to say that they think there would be considerable savings if there was some more rigor in terms of the types of devices that are approved and having lower rates of revision. Thank you.

Senator RUSTON: I have a couple of questions on e-cigarettes and where the TGA is or is not, as the case may be, on their availability in the Australian marketplace. On the government's website it says that products claiming to help people quit smoking are therapeutic goods and the importation or supply of therapeutic goods is illegal unless they have been approved by TGA. My understanding was that a vaporiser, which I have here, is not illegal but if you put a tobacco or nicotine based product in it then it is illegal. Is that correct?

Prof. Skerritt: There are some differences between states because there are some moves to more closely regulate at a state level and some that do not even contain nicotine. I will restrict my comments to the Commonwealth regulatory framework for which we are responsible.

At the moment the importation of e-cigarettes or their devices that do not have nicotine—and therefore are not for therapeutic use—does not come under our legislation. If you want to import a device which has nicotine in it for the purposes of giving up smoking it is possible to do so under what is known as a personal importation scheme but you have to have a valid doctor's prescription. If you are from a jurisdiction where these things are regulated as medicines—and internationally some countries treat them as medicines and some countries treat them as tobacco products—that is where FDA's head currently is and some countries are still working out what to do.

Senator RUSTON: Are we one of them?

Prof. Skerritt: For us, if the product is for therapeutic use it is a medicine. There is a broader review of the regulation of e-cigarettes soon to start from a policy standpoint, but the current position as of today is that if they make therapeutic claims they are a medicine and would be assessed as such.

Senator RUSTON: So, it is not illegal in most jurisdictions to go and buy it. I have to tell you that I went and bought this e-cigarette in a shop about 500 metres from my house in the middle of the city of Adelaide. That is a nicotine based oil in there. I might tell you he also offered to sell me hash oil and everything else as well and I managed to buy some chop chop at the Sefton Plaza. I am just interested in where we are heading with this because obviously one of the big issues is if these things are going to come in, anyway, which obviously they are, what is the process by which a regulated environment can be created through your organisation to stop this sort of stuff going on?

Prof. Skerritt: There are several things here. You have been talking about a product being assessed as a therapeutic good for smoking cessation. What you have presented us with is something that you have bought at an address where you know where it is. That brings us to the issue of nicotine, which is currently scheduled as a poison under the poisons schedule and reflected in acts and legislation in most states. What you have bought should be reported to the state authorities.

Senator RUSTON: It has been.

Prof. Skerritt: To the South Australian government?

Senator RUSTON: The police. I told the police what had happened. I want to know what you tell someone in the community who wants to get an e-cigarette or wants to start importing these as a therapeutic good? What is the process that they need to go through to enable this to become a legal product?

Prof. Skerritt: I outlined that at the last estimates hearing. Essentially if they want to import it as a therapeutic good they have to apply for registration of the product as a medicine through TGA on the Australian Register of Therapeutic Goods.

Senator RUSTON: And that has not happened to date?

Prof. Skerritt: We are not able to confirm or deny particular applications for particular products. That has been a longstanding policy. There are no products currently on the register that are in the shape of an e-cigarette. There are obviously other products such as gums or inhalers and so forth.

Senator RUSTON: So, you cannot tell me whether any potential importer of these products for a commercial purpose, and not just for personal use, has sought to have them registered for that?

Prof. Skerritt: In common with all medicines we cannot confirm or deny the application for commercial reasons.

Mr Bowles: Other than there is none on the register.

Senator RUSTON: Yes. Obviously the process has not been concluded. So, my answer to anybody who is wanting to import them is that they should be making application to TGA?

Prof. Skerritt: Yes. We would be very happy to take a phone call and explain the process if it is not clear from our guidance.

Senator RUSTON: On the back of that, does TGA play any role in the regulation or the marketplace for this which is illegal, which obviously is in contravention of the laws? Do you do anything there or do you just assess them for registration?

Dr Kelly: If it portrays itself to be a therapeutic good, if it makes claims that meet our definition—

Senator RUSTON: The man in the shop said to me that this would help my husband give up smoking.

Dr Kelly: Does the product itself say that?

Senator RUSTON: They take it out of the box. They do not give you the box. They take it out of the box and they give you it.

Dr Kelly: If a good is represented to be a therapeutic good, and that is through its advertising, promotion, labelling and websites, it may well fall under our jurisdiction, in which case we have some compliance responsibilities and we can take a various set of actions to stop that from happening.

Senator RUSTON: So, you would rely on it being reported back to you. So, I report this to the police and the police report back to you. Do you do anything active in that space yourself?

Dr Kelly: Again, you are thinking that might be a therapeutic good. We would need some information to convince us that was a therapeutic good. The way you have presented that here it looks like a vial of nicotine liquid.

Senator RUSTON: It looks pretty dodgy.

Dr Kelly: My sense is that it is best reported to the South Australian health authorities. They are the ones who regulate the supply of nicotine in their state.

Senator RUSTON: Thank you very much.

Senator LEYONHJELM: Did you mention that there is a review of e-cigarettes in a journal? Did I hear you correctly?

Dr Studdert: I think the review that Professor Skerritt is referring to is being conducted by the Population Health Division so you might ask that under that outcome.

Senator LEYONHJELM: Of specifically e-cigarettes?

Dr Studdert: I believe it is looking at the regulation of electronic nicotine delivery systems and other non-regulated forms of tobacco.

Senator LEYONHJELM: So, you are not answering only on your own behalf here. Is it at the instigation of anybody or is it just departmental?

Dr Studdert: I could not answer that.

Senator LEYONHJELM: You do not know. Thank you.

Senator RUSTON: Does the department or the TGA have a view on the possibility of e-cigarettes contributing to positive health outcomes?

Dr Studdert: I think the key point in that space is the NHMRC statement of March of this year, which said that at this stage their review indicated there was insufficient evidence to support the smoking cessation claims. There is a variety of studies underway around the world and certainly the outcomes of those are quite mixed in terms of the long-term smoking cessation impact of them.

Senator RUSTON: I am assuming, Professor Skerritt, that you would be requiring a level of substantiated research to suggest that there was positive and beneficial outcomes similar to patches or gum or whatever before you would consider it.

Prof. Skerritt: This is the same for any registered of medicine, whether it is the latest cancer drug or whether it would be a company coming to us with an anti-smoking product. There are some other anti-smoking products. Some antidepressants actually have somewhat of an anti-smoking nicotine deterrent activity so this is not new ground. We usually require evidence from clinical trials independently done under appropriate conditions, documented, statistically validated and so on. It is the same criteria that would be required for registration and evaluation of a medicine. You can imagine the extent of valuation for a prescription medicine and because the substances from an inhaler are likely to go right down into the bronchioles and it is likely that it would be considered a prescription medicine, the evaluation is quite rigorous.

Senator RUSTON: Thank you.

Mr Bowles: There is a broader policy issue here as well. I think there is mixed research and evidence out there around those things being used as a replacement for nicotine. You will

see some countries will come out with evidence to say that there may be some influence but I think what we are starting to see from a policy perspective is that there is more and more evidence to say that there is probably no impact at all and we are very closely monitoring that particular issue. I have also noticed, having recently talked to a whole range of countries around the use of e-cigarettes, that many countries are now starting to ban them in public places, exactly the same as cigarettes.

Senator RUSTON: I noticed on Qantas for the first time the other night they said that you could not smoke including vapour cigarettes.

Mr Bowles: In a lot of the European countries in particular they are a little bit more prevalent than they are in Australia at this particular point, but many of those countries are now starting to move to banning them in any areas in a similar way that they are banning cigarettes. It is something we are very closely looking at, at this stage. Prevalence in Australia is not high at this stage and hopefully we can keep it that way.

Senator RUSTON: We are certainly starting to see a few more of them. When would I ask you about your outcomes of your plain packaging on cigarettes?

Mr Bowles: In outcome 1, which is later on. We are running a bit late so it could be any time after 4.15. I am sorry, it is 3.30, Population health.

Senator RUSTON: Is that where we are?

Mr Bowles: We have moved on since I was there. Have we skipped outcome 8?

CHAIR: No. We are still on outcome 7.

Mr Bowles: We are on outcome 7.

Senator RUSTON: So, we are not in Population health?

Mr Bowles: No, it is outcome 1—I was right. We are not there.

Senator RUSTON: Thank you very much.

CHAIR: Are there other questions in this outcome? Are we finished with 7?

Senator McLUCAS: Yes.

Department of Health

[15:34]

CHAIR: We will now move onto outcome 8.

Mr Bowles: Before we do that I might get Mr Cormack to come back to the table and answer a couple of research questions from yesterday for Senator McLucas.

Mr Cormack: I took a couple of questions on notice that I can deal with now. Senator McLucas asked for definitions of medical research. Medical research includes research into health. Medical innovation means the application and commercialisation of medical research and the translation of medical research into new or improved medical treatments for the purpose of improving health and wellbeing of individuals.

The MRFF, which was the context of the questions, exists for the purposes of medical research and medical innovation as described. The definition of medical research is purposefully broad to include all research into health, including those for health services, primary health and so on.

In relation to the number of people on the advisory board, it will consist of up to eight members. The board will be skills based and include people with expertise and experience across areas such as health services, policy and management, health and medical research and the corporate sector, and the role of the board will be to provide expert advice to the Minister for Health on the medical research strategy and medical research priorities to inform how annual distributions from the MRFF are to be spent.

The final question was: what activities can be funded under the MRFF? It can support investment across the research spectrum from conducting research like laboratory and clinical trials, providing research scholarships and fellowships, to the commercialisation of new drugs and devices, the translation of new techniques or protocols into practice and investment in research infrastructure and facilities.

Senator McLUCAS: So, it is capital as well?

Mr Cormack: It can be used for that purpose. I think that covers off the questions that you asked.

Senator McLUCAS: Thank you. There is one question—and please take this on notice—what is the consistency with those definitions with the NHMRC definitions?

Mr Cormack: I can give you the NHMRC definition research act here. Laboratory based or clinical study or group or community based study, the causes, treatment and prevention of human disease. It also includes dental research. There is no definition of medical innovation in the NHMRC Act.

Senator McLUCAS: Thank you.

[15:36]

Mr Bowles: If we are moving now to outcome 8 this is where I said I would get people in to talk about dental and I think the other one was rural. Those people are here. If you wanted to start with those, that would be handy.

Senator McLUCAS: Would you prefer to start with those?

Mr Bowles: The people are here if you want to do that.

Senator McLUCAS: And then they can go?

Mr Bowles: Then they can go because the others have a lot more to go.

Senator McLUCAS: The first one goes to the Dental Relocation and Infrastructure Support Scheme. I understand there is a measure in the budget in rationalising and streamlining health programs. What will that mean for this program?

Dr Southern: The measure around consolidating and streamlining dental programs contributes to a saving across the forward estimates. It particularly has an impact on the DRISS, which is the Dental Relocation and Infrastructure Support Scheme. I think that was the one that came up yesterday. Basically what we are doing is having a look at that program to make some modifications to deliver it through the modified Monash model to better target the incentives to areas of need. That will take effect from July 2016.

Senator McLUCAS: The way we read the budget was that it looked like that program, the Dental Relocation and Infrastructure Support Scheme, had actually been cut completely. Is that not correct?

Dr Southern: No, that is not correct.

Senator McLUCAS: Can you explain what has been cut and what is remaining?

Dr Southern: Certainly.

Ms Shakespeare: The combined measure is a saving of $96.4 million over four years. That is achieved through ceasing the Voluntary Dental Graduate Year program and the Oral Health Therapy Graduate Year program and reducing funding to the Dental Relocation Infrastructure Support Scheme.

Senator McLUCAS: Can we disaggregate those?

Ms Shakespeare: I can disaggregate the continuing funding over the forward estimates for the Dental Relocation Incentive Support Scheme.

Senator McLUCAS: Yes, please.

Ms Shakespeare: In 2015-16 the allocation is $29.23 million. That is because there is currently a funding agreement in place that runs until 30 June 2016. In 2016-17 the funding allocation is $18.95 million. In 2017-18 the funding allocation is $19.2 million and in 2018-19 the funding allocation is $19.45 million.

Senator McLUCAS: How did that compare to the estimates prior to the change?

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

Senator McLUCAS: So, if I went to the PBS for 2014-15 I would not be able to find those figures, would I?

Mr Bowles: Not necessarily.

Senator McLUCAS: Could you find those figures for us so that we can compare?

Ms Shakespeare: Whether or not it can be compared; we do not have forward allocations by particular programs across some of our areas where they are combined. It might not be possible for us to point to published estimates for a particular program. I can certainly provide you with the funding that was previously allocated to the Dental Relocation Incentive Support Scheme in prior years.

Senator McLUCAS: I am sure you would have disaggregated it somewhere in your internal departmental thinking.

Ms Shakespeare: I can take it on notice and see what we can provide.

Senator McLUCAS: I understand that those figures that you have just read to me are providing relocation grants and infrastructure grants. Is that alone or does that include some scholarships and student placements?

Ms Shakespeare: No. Those are relocation incentive payments with some attached infrastructure where required to assist dentists relocating to more rural and remote locations.

Senator McLUCAS: Has the uptake to the program been good?

Ms Shakespeare: In the period of operation DRISS has had four grant approval rounds to date and there have been 128 relocations.

Senator McLUCAS: Was that considered successful? Was there a target?

Ms Shakespeare: The program has been underspent. It is not that we had particular targets in terms of numbers of dentists relocating; however, not all funding available in prior

years has been expended. I am not sure that we can say that the uptake has been unsuccessful; however, we had expected through previous funding allocations that more relocation incentives would have been required.

Senator McLUCAS: The cost might have been smaller for individuals than the original figuring?

Ms Shakespeare: That may be the case. For instance, I do recall that there has been less requests for infrastructure funding than we initially expected.

Senator McLUCAS: People are potentially buying other practices that are existing or people are retiring from?

Ms Shakespeare: Possibly.

Senator McLUCAS: With the reduction in funding how many relocations do you expect will be able to be delivered, say, in the 2016-17 year, given there is an average for what it costs to relocate dentists to the rural areas?

Ms Shakespeare: We have a piece of work to go through to redesign the program. As Dr Southern said, it will be redesigned to align with the modified Monash classification system rather than the current remoteness areas classification system. We will need to work through how many relocations we would expect under the new system once it is developed. However, given that the program has been underspent, we do not expect that there will be a reduction in the number of relocations that can be supported.

Senator McLUCAS: That is not really the question I am asking. I understand that the geographical spread might be different and we will not get one in Cairns, that is okay, but there must be an average cost of relocating a dentist into a rural area. With the reduction of about $10 million from this 2015-16 year where I think I understand you to say that the contracts have actually been signed for that year, then we lose 10 in the next three years. What is the profile of relocations that that amount of money could fund?

Ms Shakespeare: I can give you information on the profile of relocations that have been funded under the program but all program funding has been extended, as I said before. Under the four grant rounds that have been held by the administrator, Rural Health Workforce Australia, we have had 54 dentists relocate from metropolitan areas to inner regional RA2 locations. We have had 41 dentists relocate from metropolitan areas to outer regional RA3 locations. Thirteen dentists relocated from metropolitan areas to remote RA4 locations.

Senator McLUCAS: I am sorry I missed that number.

Ms Shakespeare: That is 13 to RA4.

Senator McLUCAS: It is 13 to remote?

Ms Shakespeare: Yes, and three from metropolitan areas to RA5 very remote areas. We then had 11 dentists relocate from inner regional areas, RA2, to outer regional areas, RA3. One relocated from inner regional areas RA2 to remote areas RA4. One relocated from inner regional RA2 to very remote RA5. One has relocated from outer regional RA3 to remote RA4 and we have had three dentists come in from overseas, one going to a regional area and two going to outer regional areas.

Senator McLUCAS: And the costs apportioned to those? What I am trying to find out is how much does it cost to relocate a dentist and how many dentists will be expected to relocate

with the available funds. I know you are saying that all those funds were not expended but I would just like to get a rule of thumb about how many dentists we are able to relocate, given there is a cut of about $30 million out of the funding profile.

Ms Shakespeare: I cannot give you that information at this point. As I said, the contract still runs until 30 June next year. There was a three-year funding agreement and I expect there will be some change in the number of applications between grant rounds. As programs are established we normally see an increase in grant applications, so I would need to go back to the administrators to get the costs for those 128 relocations so far. I can take that on notice.

Senator McLUCAS: I think that would help us to better understand that. Minister, $30 million is going to come out of relocating dentists to the regions. I think you would agree with me that we have not fixed the problem, but we are going to cut $30 million out of a relocation grant system.

Senator Nash: As Ms Shakespeare was alluding to, there will be some work done around that. There have been some decisions of government that very much go to the efficient use of taxpayers' dollars and the efficient use of funding, and I think there has been some realignment, if you like, in thinking of best value for these types of things and this is one of those areas.

Senator McLUCAS: So, it is not valuable investing money in moving dentists into the bush?

Senator Nash: Do not put words in my mouth like that. Living in a regional area, as you do, we probably understand the needs of regional areas better than a lot of others, but we have finite funding capacity and government has to make hard decisions about the best use of funding with programs such as these. There are sometimes changes that have to be made.

Senator McLUCAS: So, how does this policy align with the election commitment from the National Party that says, 'We will ensure that funding for regional health priorities is permanent and ring fenced. Regional health practitioners will be able to rely on funding support'?

Senator Nash: Absolutely they will, but it certainly does not say—

Senator McLUCAS: Well, they cannot. It said a $30 million cut.

Senator Nash: Let me finish. You have asked the question so let me finish. That statement certainly does not indicate ongoing programs ad infinitum for decades to come. At times there will be realignment. I think a very good example that reflects that policy exactly is the changes that we have just made to the General Practice Rural Incentive Payment program that under Labor was not targeting the areas in regional Australia where we needed it to go. That was a case in the budget that specifically aligns with what we are saying.

Senator McLUCAS: There is a cut of $30 million.

Senator Nash: There is no intention, in that statement that you were talking about from the National Party, that things would go for decades and decades ad infinitum.

Senator McLUCAS: The word was 'permanent' in the policy.

Senator Nash: Even you know in government that there are changes made from time to time to programs and policies.

Senator McLUCAS: I would not have written the word 'permanent'.

Senator Nash: Permanent does indicate the next—

Senator McLUCAS: I would not try to get a vote out of the voter promising permanency and then just rip it up.

Senator Nash: Permanent does not indicate for the next 100 years, and you well know that.

Senator McLUCAS: That is what has happened.

Senator Nash: You are playing with words. That is semantics.

Senator McLUCAS: No. Permanent means forever.

Senator Nash: If you read that again it is a broad statement and does not say that every single program will go on ad infinitum for 100 years.

Senator McLUCAS: Permanent and ring fenced.

Senator Nash: Unlike the previous government we will make sensible decisions with the use of taxpayers' dollars. It sometimes means we cannot do everything we like.

Senator McLUCAS: These words were sent out to the electorate.

Senator Nash: It sometimes means we cannot do everything we like. We have a commitment to make sure we get the budget back where it needs to be, which means sometimes we have to make difficult decisions about changes to policy.

Senator McLUCAS: You did not say that before the election, Minister.

Senator Nash: We have been saying that since we came into government.

Senator McLUCAS: That is the point.

Senator Nash: We have been saying that since we came into government, that we had to fix Labor's economic mess. We got into government because people elected us to fix your mess.

Senator McLUCAS: You promised permanency and then straightaway we can cut everything.

Senator Nash: You are playing with words and everybody listening will understand.

Senator McLUCAS: It is $30 million out of rural dental transfers.

Senator Nash: Everybody listening will understand.

Senator McLUCAS: I think my point is made.

Senator Nash: I do not think that it is at all.

CHAIR: A couple of minutes and then we will go to Senator Reynolds.

Senator McLUCAS: The other one that we indicated to do now goes to the Health Portfolio Flexible Fund. Should we do that one here?

Mr Bowles: In relation to what?

Senator McLUCAS: Is the Rural Health Outreach Fund in this section?

Mr Bowles: Yes.

Senator McLUCAS: This goes to the health portfolio flexible funds and the one in particular is the Rural Health Outreach Fund. How do the changes to the flexible funds reflect in changes, if any, to the Rural Health Outreach Fund?

Dr Southern: As we discussed yesterday, the allocation of savings across the flexible funds for the 2015-16 budget measure is something which is still under consideration, and that goes equally for the way that any savings will be allocated to the Rural Health Outreach Fund.

Senator McLUCAS: What does it currently fund?

Dr Southern: The size of the—

Senator McLUCAS: No. With the Rural Health Outreach Fund, what sort of activities does it fund?

Dr Southern: It funds a range of outreach health activities in regional, rural and remote locations, basically working with the jurisdictional fund holders to determine what the areas of need are and particularly to ensure that a range of health professionals are supported to operate in those regions. They include specialists such as paediatricians, psychiatrists and surgeons.

Senator McLUCAS: Is that the old MSOAP program?

Dr Southern: Yes, as well as allied health professionals. There are four priority areas for the fund, certainly working with maternity and paediatric health, eye health, mental health and support for chronic disease management. Those are the four areas that it focuses on.

Senator McLUCAS: Within the specialist element of the program?

Dr Southern: Yes.

Senator McLUCAS: Minister, were you consulted on the cutting of the flexible funds in the development of this measure?

Senator Nash: Not specifically the measure; obviously the funding arrangements and the budget are a matter for the senior minister, but we talk constantly about regional issues, obviously rural and regional delivery of health, on an ongoing basis.

Senator McLUCAS: So, you were aware that the Rural Health Outreach Fund was facing some cuts in this budget?

Mr Bowles: Can I just interject because this goes to a conversation we had yesterday morning where I said we have not cut anything at this stage. This is the work that we are going to do over the next couple of months to understand what is the best way to deal with the savings attached to flexible funds more broadly. There is no indication yet on the individuals. If you remember yesterday I talked about two; one was Indigenous and one was medical indemnity.

Senator McLUCAS: So, a decision to quarantine two of the flexible funds has been made?

Mr Bowles: Yes.

Senator McLUCAS: That only lets me come to the conclusion that the other 16—

Mr Bowles: It is 14.

Senator McLUCAS: That is right. Two went the other way. Fourteen will be facing some cuts.

Mr Bowles: We will be having a look at the other 14 and we will be making decisions about what is the best way across 14. It could be across 14; it could be across five; it could be

across 11; it could be across whatever. We have not determined what that is at this particular point. It is a little bit early to say that particular fund itself will face cuts.

Senator McLUCAS: When will we know that?

Mr Bowles: Over the next couple of months we said we would do that and working towards the end of the year. It will be the next three, four or five months to make sure that we have got things in place later in the year.

Senator McLUCAS: That is all I will ask on that.

Senator REYNOLDS: I have a follow-up question to Senator McLucas's last question. Is my recollection correct from the testimony yesterday on flexible funds that while you will be reviewing the 14 funds, as you said there might be some changes, but indeed some of those might end up with more in terms of reprioritisation if they are actually a greater priority?

Mr Bowles: There is potential that when we look at the whole 16 funds we might look at a completely different way of configuring funds that could mean that there are less funds, separate funds, trying to reduce administrative overheads and things like that. That is what I talked about yesterday. We will take the opportunity to actually look at reducing administrative overhead and any duplication through the funds that might allow us to deal with savings in quite a different way.

Senator REYNOLDS: In a flexible way?

Mr Bowles: In a flexible way, yes. We did have that conversation yesterday.

Senator REYNOLDS: Thank you.

CHAIR: It is near enough to four o'clock so we will break until quarter past.

Proceedings suspended from 15:58 to 16:16

CHAIR: We will resume. Senator Reynolds.

Senator REYNOLDS: Minister and secretary, I would like to raise the Curtin Medical School and the recent announcement on the school itself. As I mentioned yesterday I, somewhat bravely I thought, attended the AMA conference on the weekend and, as a supporter of the Curtin Medical School, I was not quite sure whether I was jumping into the lions' den or not. What became very clear to me after a number of robust but informative discussions was that there is not a unanimity of opinion in the medical profession on the school and it appears that there are some possibly misunderstandings about some of the issues. If I could, I would just like to go through a few of the issues that were raised. Can we get the Commonwealth's perspective on that? The first one is, can you give us a general overview of the proposal, also what agreement was reached and what were Commonwealth and what were state responsibilities in the new school?

Mr Bowles: I might ask Ms Shakespeare to start with that and give us some detail on the program itself.

Ms Shakespeare: The proposed Curtin Medical School will be an undergraduate direct entry medical degree program. At the moment, in Western Australia there are only graduate entry programs available at the University of Western Australia and the University of Notre Dame. It is a direct entry, so people can go straight into medicine after completing high school. The proposal is for 60 commencing Commonwealth supported medical places in 2017. They will not be funded by the Commonwealth at that stage, though. Curtin is

absorbing the costs associated with the Commonwealth's normal contribution to it through the Higher Education Contribution Scheme for those students.

Senator REYNOLDS: What would that normally be for 60 places?

Ms Shakespeare: I am afraid that you would have to ask that question to the Department of Education. I do not have that level of detail here with me.

Senator REYNOLDS: No, that is fine.

Ms Shakespeare: The Commonwealth contribution per place for medicine is in—

Senator REYNOLDS: Are they fully funding it?

Ms Shakespeare: If it was a normal Commonwealth supported place I think it is in the order of about $12,000 per student, per year and then there is a student contribution on top of that through the Higher Education Contribution Scheme. The number of Commonwealth supported medical places, so domestic HECS students, would increase 10 per year to reach the full 110 commencing student places per year in 2022. We would reach full capacity of 550 students in training at any one time in 2026.

It is proposed that the Commonwealth contribution for the Commonwealth supported places would commence after the 2018-19 financial year, so 2019-20. There is also an intake of 10 full fee paying international students proposed at the school. In terms of other funding that we are aware of, there has been a commitment from WA of $22 million towards capital costs associated with establishing the school and Curtin University is contributing $67 million in capital funding.

The other information we have around commitments to support the school is that the Western Australian government has committed to providing the additional clinical placement and supervision requirements for the additional students starting from 2016-17, and has also made a commitment to provide the additional internships required once the students graduate and the additional required specialist training positions once they get through their internship and junior doctor training.

Senator REYNOLDS: In relation to the plan for placements and the supervision, obviously one of the big concerns of the AMA at the moment is that there is not going to be enough. If your understanding of the state guarantee—so, those additional 60 to start off with and then rising to 550 in studies, in addition to the other two medical school requirements. So, will all three schools' requirements be met by the state government?

Ms Shakespeare: Yes. The commitment was to provide the additional clinical training places, internships and specialists places on top of the existing commitment to students in Western Australia.

Senator REYNOLDS: The supply of GPs is a perennial issue, not just Western Australia, especially in rural and regional areas. In WA, particularly, we have had numbers thrown around, some saying that there is a shortage of GPs in Western Australia and others saying that there is not; to me it appears as if the argument is where the GPs are actually physically located. Coming from the eastern suburbs myself, I know there is a shortage there in metropolitan Perth. Certainly, going out to rural and regional areas, everywhere I go one of the biggest issues people have is not having access readily to a GP. Has the department got

any comments? That issue of GPs must have obviously gone into the consideration of this school.

Ms Shakespeare: Yes, and we have been working to increase GP registrars in training in Western Australia over a number of years now. In 2012 there was an agreement reached with the Western Australian government to increase internship availability and that the Commonwealth would also increase numbers of GP registrars in training by, I think it was, 60 additional registrar positions. I would probably just need to check that number. My recollection is getting a bit hazy from 2012. That happened over two years, and we achieved those additional GPs in training.

There has also been a further increase this year in GP registrar allocations to Western Australia; however, we are still going through the process of people applying for those positions, so we do not have final numbers. The efforts are to increase the numbers of GPs training in Western Australia. There are certainly some issues around the availability of training positions outside metropolitan areas in Western Australia.

Senator REYNOLDS: Is the issue of not just the GP training itself, but where they are located, an issue for the state government or the Commonwealth government?

Ms Shakespeare: I think it is something we would like to work in partnership with the WA government to do. I have certainly spoken to the WA health people recently about undertaking more detailed workforce planning in Western Australia so that some of the additional doctors that will now be produced through the Curtin Medical School can now be trained in general practice. If we start the work now to develop supervising practices so that we can meet some of the Commonwealth's requirements around GP training. For instance, we have 50 per cent of GP training needing to be on the rural training pathway, so we will need to build up supervisory capacity, GP training capacity, outside of metropolitan areas to continue to meet that target nationally.

Senator REYNOLDS: Would that development work with the state government and, presumably, Curtin University, be just for the trainees and the sort of going through from Curtin, or is that a program more widely for those coming out of all three medical schools?

Ms Shakespeare: That is more broadly. We would like to look at the WA medical training pipeline in total. That also involves looking at specialist training opportunities in Perth. We are currently starting a process to go through and review the Commonwealth's investment in specialist training to see if more of the specialist training positions can be located in rural and regional locations. I have had recent discussions with doctors in Albany who are quite keen to undertake more training in psychiatry and palliative care.

Senator REYNOLDS: That is good.

Ms Shakespeare: Those are the sorts of things that we want to work with the WA government to coordinate.

Senator REYNOLDS: As part of this agreement, was there particular discussion or focus with Curtin on what they themselves will do to try and encourage more training positions in the eastern suburbs and also rural and regional areas?

Ms Shakespeare: Yes. We are still at an early stage of those discussions with Curtin. Curtin has voluntarily indicated that it will have intakes of students that are focused on the people from a rural background and outer metropolitan background—around the midlands

area in Perth. They have certainly flagged that they would like to participate in the Rural Clinical Schools Program. That is still something that needs to be considered and decided by the government, though.

Senator REYNOLDS: As a strategy to get more people to go back, it is looking to provide more opportunities for those students to come and train in the city but then go home. Is it just an issue of the training places, or how they recruit? I know that a lot of students from rural and regional areas have great difficulty in affording to come to the city. That is obviously not your particular area, but has there been any discussion with any other Commonwealth agency in terms of making it more affordable for students to come and relocate to Perth for their studies?

Ms Shakespeare: There is a range of scholarship programs that are provided across the Commonwealth. Some are from the health portfolio. Others are through the education portfolio and the universities directly. There would be support. One example is scholarships that we have in operation at the moment for rural medical students; that would be available.

Senator REYNOLDS: I know there was a scholarship proposal that was part of the package of the higher education reforms. It did not get through the Senate, but obviously if they do not go through the Senate then, if it is to be successful, we need to find other ways of making sure that those students can take advantage of these opportunities. Another issue that has been raised goes back to the statistics. Do you have any statistics federally that would indicate whether there is a shortage or there are less per head of population of doctors and GPs in WA than any other state?

Ms Shakespeare: Yes. The statistics do show that WA has the lower doctor-to-population ratio than the eastern states. There has been some work done by local consultants in Western Australia that has estimated the comparative shortfall. If there were the same number of doctors to population in Western Australia they would have an additional 950 doctors there. That gives you an indication of the relative gap. There are certainly a lot more internationally trained doctors in Western Australia compared to other parts of Australia.

Senator REYNOLDS: Is that in actual numbers or comparatively?

Ms Shakespeare: In Western Australia there are about 54 per cent of the doctors that were trained in Australia. The national average is 63 per cent.

Senator REYNOLDS: That is quite a gap. Are you saying that almost half the doctors in WA are foreign trained?

Ms Shakespeare: That is right.

Senator REYNOLDS: Thank you.

Senator MOORE: Some of the questions I have Senator Reynolds has asked about to do with the Curtin Medical School. I just want to follow up on a couple of points. I am wanting to know whether the department provided the minister with the brief on the Curtin Medical School prior to 17 May?

Ms Shakespeare: The Curtin Medical School proposal has been around in various forms since about February 2011. We have provided advice to several health ministers over the course of that time, yes.

Senator MOORE: When was the last advice provided?

Ms Shakespeare: We would have to take that on notice.

Senator MOORE: Can you tell me whether you supported the school?

Mr Bowles: We provide advice to government and government makes decisions.

Senator MOORE: Was the National Medical Training Advisory Network consulted on the announcement that there would be a new medical school in Perth?

Ms Shakespeare: No; however, advice from the National Medical Training Advisory Network was taken into account in terms of advice provided to government.

Senator MOORE: I do not understand that.

Ms Shakespeare: The National Medical Training Advisory Network provided advice on projections in Australia's Future Health Workforce Doctor's Report, which was published in December last year. The recommendations made by the National Medical Training Advisory Network in that report, in response to the most likely projection in the opinion of the NMTAN, was that Australia was likely to have a small oversupply of doctors by 2030. The NMTAN recommended in response to that, that over time immigration numbers of doctors be reduced to around 67 per cent of current levels.

Senator MOORE: But was it not asked for advice or provide advice on a new medical school in Perth?

Ms Shakespeare: Not directly.

Senator MOORE: I just thought I must have missed something in that. Was the National Medical Training Advisory Network consulted when previous schools had been established?

Ms Shakespeare: The National Medical Training Advisory Network was established in 2012 and I think first met in early 2013.

Senator MOORE: Have there been none since then?

Ms Shakespeare: No.

Senator MOORE: You went through the funding, thank you, and I have written down the Western Australian government and the Curtin University's contribution, and also that Commonwealth funding will begin in 2019-20. Is that right? How much funding is going to be provided at that time?

Ms Shakespeare: That is a question that I think you would need to direct to the Department of Education and Training.

Senator MOORE: So, is there no money coming out of Health?

Ms Shakespeare: There has been no funding considered or approved out of Health at this point.

Senator MOORE: Will it probably be out of education as an education commitment?

Dr Southern: They bear the costs of the Commonwealth supported places, yes.

Senator MOORE: Do you know whether the agreement between the federal government and the state government to commit to the school has been signed? If you do not know, you do not know.

Dr Southern: That is a question for Education.

Senator MOORE: When was the Postgraduate General Practice Placement Program actually wiped out?

Ms Shakespeare: The program itself ceased around the end of 2014; however, I am reluctant to give you an exact date because there were some rotations that continued on for a couple of weeks into 2015, I think. Largely, it ceased at the end of December last year.

Senator MOORE: What was going to be the alternative to that? I was interested in the conversation you were having with Senator Reynolds about the need for general practice. It was my understanding that the PGPPP was actually particularly introduced to have that postgraduate focus on general practice. That scheme was actually terminated around 2014; what was the proposal to take on the responsibility for those training places?

Ms Shakespeare: I am sorry, I do not understand the question.

Senator MOORE: I am wanting to find out what was supposed to replace the training proposals when the PGPPP was wiped out? That was a program that was looking at specific training places for general practice. That was my understanding. That was what it was developed to do and that was the process. It was not around very long and then it was terminated in 2014. What was the proposal through the workforce strategy to look at postgraduate training in general practice from then on?

Dr Southern: I think one of the issues around the PGPPP was when it was originally established there was insufficient demand for GP training places from junior doctors. We have a completely different situation now where the Australian GP training program is now oversubscribed. In one sense, while the GP training program is different from the intent of the PGPPP, we are providing and meeting the demand for GP training through the broader GP training program.

Senator Nash: If I could just add onto that too, just to clarify: you are quite correct, the PGPPP program did cease. Where the concern has been—and there were a number of things in the PGPPP program that necessitated that any one of which was a cost—I think as you would be aware, one of those placements averaged out at about $60,000 for the 12 weeks as compared with the GP registrar at around $60,000 for a whole year. A lot of them, from memory—and I stand corrected—I think at least 30 per cent were going to metropolitan areas at the time. There was a range of reasons why it was appropriate to cease that. However, in that of course is the bit I think you are referring to, which is the junior doctor exposure to rural practice. While that PGPPP has ceased, I have indicated that the government is aware of those concerns, and that particular aspect is being considered in terms of the pipeline issues we are looking at more broadly.

Senator MOORE: The pipeline process and also the direction of the pipeline, which was supposed to be to all areas.

Senator Nash: That is right. There is a lot of commentary, as I am sure you are well aware, about the pipeline and joining up our students from when they are going in at this end to where they are coming out at the other end, and this is part of a broader piece of work around doing that. In this instance it is particularly focused on that junior doctor exposure to rural practice; I am well aware of it. I expect that that is the part to which you are referring.

Senator MOORE: I am, and I want to see if there are any proposals for alternative programs to respond to that identified need.

Senator Nash: Nothing as yet, except to confirm for you that we are considering that in the broader pipeline.

Senator MOORE: Do you know how many students were supported through the PGPPP?

Ms Shakespeare: In the final year there were 975 rotations with an average length of 12 weeks supported.

Senator MOORE: A rotation of individual students?

Ms Shakespeare: Yes.

Senator MOORE: You were talking about the fact that the Western Australian government has made a commitment to provide the extra training places necessary to process doctors to do what they have to do. Do you have any idea for how long that commitment has been, and how many places that will be? What are the terms of the commitment?

Ms Shakespeare: The commitment is to provide the additional clinical training and supervision support for the numbers of students that I read out earlier.

Senator MOORE: That is 550 from 2026?

Ms Shakespeare: Yes.

Senator MOORE: So the Western Australian government has committed to providing those training places in its hospital networks for how long?

Ms Shakespeare: There is no time limit on the undertaking that we have.

Senator MOORE: They have signed off on doing it, but we do not know for how long?

Ms Shakespeare: Yes.

Senator CAROL BROWN: I will ask some questions about the Health Workforce Scholarship Program. As I understand it, the health workforce scholarships are being consolidated into a single Health Workforce Scholarship Program, is that correct?

Ms Shakespeare: Yes.

Senator CAROL BROWN: How many scholarship programs are there at the moment?

Ms Shakespeare: The proposal to consolidate into the Health Workforce Scholarship Program involves the Nursing and Allied Health Scholarship and Support Scheme, the Rural Australia Medical Undergraduate Scholarship Scheme, the Puggy Hunter Memorial Scholarship Scheme, General Practice Scholarships, Diagnostic Imaging Enhancing Rural and Remote Workforce Scheme, and the Medical Rural Bonded Scholarship Scheme, so that is six.

Senator CAROL BROWN: How many scholarship programs are operating? Are they all being consolidated into one program?

Ms Shakespeare: From the Health Workforce Division's Health Workforce funded scholarships, yes.

Senator CAROL BROWN: So all six are going in. There are no other scholarships that will not be included. Why are we doing this?

Ms Shakespeare: First of all, it is to allow greater flexibility in the direction of scholarships to workforce planning data and projections, so that we can respond to the work that the department now does in projecting expected shortages and over-supplies in health

workforces. We can then target resources at those we expect to be in undersupply. Also, the change to the scholarship program is going to introduce a rural return of service for most of the scholarship recipients under the new program. It will also reduce administrative costs associated with having a lot of smaller scholarships programs by having a single administrator.

Senator CAROL BROWN: What work was undertaken to come to form that view?

Ms Shakespeare: We have had several policy developments. There was a review of health workforce programs in 2011 which did recommend that we look at further consolidating scholarships. I suppose it is responding to that recommendation and also looking at how we can get more responsiveness in our health workforce programs to the health workforce planning work that the government now undertakes at a national level.

Senator CAROL BROWN: That is 2011; when did it come back on the—

Ms Shakespeare: Sorry, 2013.

Senator CAROL BROWN: I think you mentioned the Puggy Hunter scholarship?

Ms Shakespeare: That is right.

Senator CAROL BROWN: Are there any other scholarships targeted at Aboriginal and Torres Strait Islander people?

Ms Shakespeare: Those are our main scholarships targeted at Aboriginal and Torres Strait Islander health students.

Senator CAROL BROWN: That one scholarship?

Ms Shakespeare: That is expressly for Aboriginal and Torres Strait Islander health students. There may be Aboriginal and Torres Strait Islander students studying with support under other scholarship programs.

Senator CAROL BROWN: But this is the one particularly targeted to Aboriginal and Torres Strait Islanders. With the new scholarships, will they include measures to ensure that Aboriginal and Torres Strait Islander people continue to be targeted?

Ms Shakespeare: The government has specifically decided that the Puggy Hunter scholarships will be preserved at current levels. So there is no reduction in scholarship numbers. We will also retain the branding for those scholarships. There will be no rural return of service obligation on those scholarships because the challenges with building the Aboriginal health workforce are across Australia, including in metropolitan areas.

Senator CAROL BROWN: If all six are consolidated into one, how will that branding be preserved?

Ms Shakespeare: There will be a single administrator and we expect a single round calling for scholarships each year, but there will continue to be a separate allocation of scholarships called the Puggy Hunter scholarships.

Senator CAROL BROWN: Under that one consolidation, okay. Are the medical rural bonded scholarships being consolidated into the program?

Ms Shakespeare: The arrangements for the medical rural bonded scholarships are slightly different. That scheme will actually cease at the end of this year. However, we do have commitments under this current year's cohort and previous years for scholarships until the

completion of their studies. So those scholarships will be met. However, from next year an additional 100 bonded medical places will be offered with no scholarship attached.

Senator CAROL BROWN: How many are we talking about? How many are currently in the MRBS?

Dr Southern: It is 100 each year. The total number of students in the program at the moment, is that what you are looking for?

Senator CAROL BROWN: Yes.

Ms Shakespeare: I think it is in the order of 1,200 but that might include participants who have finished and are still to complete their return of service obligation. I would have to take that on notice.

Senator CAROL BROWN: What was the purpose of the medical rural bonded scholarships?

Ms Shakespeare: The program provides a scholarship over the course of medical studies. It can be between four and six years, depending on the length of degree. Once a student has graduated and completed the rest of their post-graduate medical training and qualified as a specialist, they would be required to complete a rural return of service, and I think in the case of the MRBS, that is six years.

Senator CAROL BROWN: With that service, what areas are we talking about?

Ms Shakespeare: For the MRBS scheme, it is remote areas 2 to 5, under the ASGS classification.

Senator CAROL BROWN: So outside regional—

Ms Shakespeare: Outside the metropolitan area.

Senator CAROL BROWN: You might not be able to answer this here, but were the recipients of these scholarships mainly from rural and remote communities?

Ms Shakespeare: No, that is not necessarily the case. They were open to all applicants.

Senator CAROL BROWN: I know they were open to all applicants; I am asking were the recipients mostly from rural and remote communities?

Ms Shakespeare: We would have to see if we could collate that information for you. I am not sure if we have the information about where the recipients were from. We would have to check with our Grants Services Division.

Senator CAROL BROWN: You mentioned the return to service—is that what you called it?

Dr Southern: It is rural return of service

Senator CAROL BROWN: The returns of service obligations for the bonded medical placement schemes have changed, is that right?

Ms Shakespeare: Yes. There will also be a change to the bonding requirements under the Bonded Medical Places Scheme, which is different from the MRBS scheme. At the moment the rural return of service obligation is between four and six years, depending on the length of medical degree for which the person received a bonded medical place but not scholarship. That will reduce from next year to 12 months. However, that does not reduce for existing

participants who have signed contracts with the Commonwealth. So their continuing obligations as they entered into those contracts will remain.

Senator CAROL BROWN: The 100 supported places that you mentioned earlier will have a reduced service obligation?

Ms Shakespeare: The Bonded Medical Places program actually applies to 25 per cent of all commencing medical students each year. From next year, it will be 25 per cent plus the 100 places that were previously offered under the MRBS scheme. That takes the total to, I think, about 28.5 per cent of commencing medical students that will be bonded.

Senator CAROL BROWN: But they will have reduced return of service obligation?

Ms Shakespeare: Twelve months.

Senator CAROL BROWN: From four to six, depending on their degree. Why has that been put in place?

Ms Shakespeare: The best available evidence that we have about program effectiveness in encouraging people to work in rural areas after they have graduated is probably from the Rural Clinical Schools Program—and also this was studied and found to be the case in the review of health workforce programs in 2013—those students who are undertaking 12 months' worth of training in rural areas are more likely to return to those rural areas. So that seems to be an effective length of time in a rural area. We have had less success to date with the longer bonding periods under the Bonded Medical Places and MRBS schemes, so we have quite high numbers of people who have withdrawn from those schemes, either by breaching their obligations or, in the case of the Bonded Medical Places program, by pulling out of that obligation by paying off their obligation to the Commonwealth.

Senator CAROL BROWN: Do you have any figures that you can give me to support that?

Ms Shakespeare: For the Medical Rural Bonded Scholarships Scheme, we currently have 1,394 active participants. Of these, 108, or 7.7 per cent, are completing their return of service obligation. We still have 36 qualified fellows who we are not sure whether or not they will commence their return of service or if they are going to breach. We have a total of 95, or 6.8 per cent, who have withdrawn from their scheme or breached their agreement. Obviously there are a lot of people still completing their studies or who are not subject to the requirement to do the return of service yet, because they have not completed their medical training. As you can imagine, medical training continues over a number of years. For the Bonded Medical Places Scheme, as of 11 May we have 6,295 active medical students and doctors in the scheme; 37 are completing their return of service obligation, which is a bit less than 1 per cent, and we have had 307, or about 5 per cent, withdraw from the scheme or breach their agreement.

Senator CAROL BROWN: Do all of the rural scholarships have a return of service of six years, or has it been scaled back? Can you scale? Is there a mechanism where you can reduce that service?

Ms Shakespeare: There is under the Bonded Medical Places program, but not under the MRBS.

Senator CAROL BROWN: Where did you say the evidence was produced for the scaling back of the service?

Ms Shakespeare: The best evidence about the impact on our health workforce programs is the Rural Clinical Schools Program. We have quite a lot of evidence from various sources now. I can take you through those if you like. That program has had a good impact on rates of people going back to work in rural areas once they have qualified. One of the main components under that program is supporting 25 per cent of medical students to undertake 12 months' worth of clinical placements in rural areas. That seems to be the length of time being spent in rural areas that is having the biggest impact in terms of return to rural service rates.

Senator CAROL BROWN: Are you confident that these changes will retain doctors in rural communities? You mentioned earlier that 12-months' service has doctors and other medical professionals going back to those communities?

Ms Shakespeare: It is the best available evidence that we have. It is very hard in workforce programs to isolate what particular program or aspect of someone's training career or work career is the influencing factor in their decision to return to rural practice. From the evidence that we have, the peer reviewed research, that program is having an impact, and it is the best available evidence about what is having an impact on getting and retaining a rural workforce.

Senator CAROL BROWN: The aim obviously is to have doctors and other medical professionals working and living in rural and remote areas. I am a bit concerned whether this will be achieved by these changes. You have talked about some evidence about that. Has the department done any work by the department with the rural bonded medical scholarships as to why people broke their service obligations?

Ms Shakespeare: Yes, we have quite a lot of work in dealing with applications from people to be released from their obligations. We do have a good idea of what the reasons are that people put forward. As I said, we have looked at that evidence about the numbers of people who are completing their obligations and the numbers that have been pulling out. We have looked at the evidence from our rural clinical schools. We have looked at the recommendations from the review of health workforce programs. I think we have tried to pull together the best available evidence to support those policy changes.

Senator CAROL BROWN: But you do not know whether or not this new direction will work?

Ms Shakespeare: The best available evidence indicates that it is likely to be successful. However, I cannot give a guarantee.

Senator CAROL BROWN: In the budget measure, it says there are $72.5 million in savings arrived at. Can you take me through where those savings are? Is there any reduction in scholarships offered?

Ms Shakespeare: We have had this discussion before. It is quite difficult to say that there is a particular number of scholarships that will be offered in any particular year, because it does depend on the type of scholarships that people apply to undertake. We do expect that there will be an overall reduction in the number and value of scholarships, because there is a saving, as you say, in the budget of $72 million from the scholarship program. Part of that

will be achieved through reductions in administrative costs, but there would also be an overall reduction in scholarship numbers.

Senator CAROL BROWN: What are we looking at? You obviously advertised for people to apply for scholarships. You must have a set figure as to how many you are going to award? If they are undersubscribed, they are undersubscribed. What is the reduction?

Ms Shakespeare: There is no set number of scholarships. People may apply for scholarships to do undergraduate study, postgraduate study, clinical placements and continuing professional development, CPD, courses, particularly under the Nursing and Allied Health Scholarships Support Scheme. So the numbers do vary. The overall funding and the number of scholarships that it can support varies from year to year.

Senator CAROL BROWN: Can you explain to me in more detail where the $72.5 million in savings is arrived at? There is a reduction in scholarships; you have told me that. How much of that $72.5 million is saved from the reduction in scholarships, and how much is saved in a reduction in administrative costs?

Ms Shakespeare: We are yet to conduct the approach to markets to find a new administrator for the consolidated scheme. It will be difficult to work that out until we have done that.

Senator CAROL BROWN: How did we then arrive at a figure in the budget?

Ms Shakespeare: I can tell you about how that has been allocated over the forward estimates years, but the figure is the figure.

Senator CAROL BROWN: Okay; tell me how it has been allocated over the forward estimates?

Ms Shakespeare: Savings in 2015-16 are $14.2 million; in 2016-17 the savings are $17.6 million; in 2017-18 they are $19 million; and in 2018-19, $21.7 million.

Senator CAROL BROWN: They are the savings, but I just do not understand how you can work out savings if you do not know—

Mr Bowles: Again, it is part of the budget process. The outcome of the budget process is through a whole range of different scenarios. The number for this one is $72.5 million.

Senator CAROL BROWN: I understand that; I am just trying to get my head around how you make savings, or you do not know where your savings are from. I expect most people putting household budgets together would understand where their savings are coming from.

Mr Bowles: I think Ms Shakespeare has already said that there will be administrative savings. Once the program is put together and we have an administrator for that, we will understand what those administrative savings are and we will understand the number of scholarships that are given out. As Ms Shakespeare said a number of times, it varies from year to year.

Senator CAROL BROWN: Yes. So you have a saving of $72.5 million, and depending on what savings you can make in the reduction of administrative costs, that will then decide how much money you can spend on your scholarships?

Mr Bowles: That is largely how it works, the same way it works every year.

Senator CAROL BROWN: Are new scholarships being offered?

Ms Shakespeare: It will be a new scholarship program.

Senator CAROL BROWN: Can you give me the breakdown, if you can, of the new scholarships by profession?

Ms Shakespeare: No.

Senator CAROL BROWN: You will be able to next year, I expect.

Ms Shakespeare: Again, subject to the caveat that there may be different types of scholarships funded under the program, and there will not necessarily be targets set for particular professions or particular types of training for professions.

Senator CAROL BROWN: I think you actually mentioned this, but I will ask it: how will the new scholarships be administered under this program?

Ms Shakespeare: There will be an approach to market to select an external administrator for the scholarship program.

Senator CAROL BROWN: When will that happen?

Ms Shakespeare: We expect later this year.

Senator CAROL BROWN: Is this all to come into effect next year?

Ms Shakespeare: From 1 July 2016.

Senator CAROL BROWN: Who currently administers the six scholarships?

Ms Shakespeare: We have different administrators. The Australian College of Nursing, Services for Australian Rural and Remote Allied Health, The National Rural Health Alliance, and GP Registrars Australia; I think those are the scholarship administrators.

Senator CAROL BROWN: What happens in terms of their contracts?

Ms Shakespeare: Their contracts will be honoured until they expire. All of those administrators will have the opportunity to apply to administer the new program.

Senator CAROL BROWN: When will those funding agreements expire?

Ms Shakespeare: I think they have different expiry dates. They will all be extended through to 30 June next year.

Senator CAROL BROWN: None of them actually goes past that date?

Ms Shakespeare: That is right.

Senator CAROL BROWN: Were those organisations consulted on this change?

Ms Shakespeare: This was a budget decision.

Senator CAROL BROWN: Okay, no consultation. Why is that? You mentioned the review in 2013. Was there consultation in that review?

Ms Shakespeare: Yes, there was certainly consultation during the health workforce program's review.

Senator CAROL BROWN: Those organisations that currently hold funding agreements were consulted?

Ms Shakespeare: I would have to go back and check. It was some time ago now. I certainly know that some of them were consulted. I remember being at consultation meetings

where the independent reviewer spoke with them. But I would have to check whether all of them were consulted.

Senator CAROL BROWN: It was felt by the department that further consultation, particularly with those that held funding agreements, was not needed?

Ms Shakespeare: This was a budget decision.

Senator CAROL BROWN: I think you told me the return of service was the same for all under the new scholarship programs, being one year, is that right?

Ms Shakespeare: That is correct, except for Aboriginal and Torres Strait Islander health students receiving Puggy Hunter scholarships.

Senator CAROL BROWN: What is their service obligation?

Ms Shakespeare: There would be no return of service obligation.

Senator CAROL BROWN: Will scaling be available under the new program?

Ms Shakespeare: No. Because the length of the return of service is much shorter, we do not think that there is a need to scale.

Senator CAROL BROWN: I think that is all I have.

Senator DI NATALE: I have a couple of quick questions on the Curtin Medical School. I understand that you went through that with Senator McLucas, so I will try not to go over old ground. What is the proportion of rural students that Curtin will be taking into their program? Have you agreed on a proportion?

Ms Shakespeare: I understand that Curtin has set its own target of 20 per cent. However, that is not something that they agree with us, because at this stage they are not participating in the rural clinical schools program under which participating universities are required to make sure at least 25 per cent of their intake is from a rural background.

Senator DI NATALE: So why was it not made a condition of the medical school?

Ms Shakespeare: Those universities that do participate in the rural clinical schools program are funded to participate in it. So the funding assists them in their additional recruitment measures to ensure they have sufficient students from rural backgrounds and can undertake the rural clinical training requirements under that program.

Senator DI NATALE: Given the nature of Western Australia, there are two other medical schools in WA, is that right?

Ms Shakespeare: That is right.

Senator DI NATALE: They have an average of 25 per cent. WA has a huge problem with the maldistribution of the medical workforce there. Why would it be taking fewer rural students than the other two universities?

Ms Shakespeare: It may be that Curtin does participate in the rural clinical schools program in the future. That has not been decided yet.

Senator DI NATALE: But you are telling me that they have an intake of 20 per cent, which is 5 per cent less than the two other medical schools. We had the ability to put conditions on what they did or did not do, and we have not done that?

Dr Southern: I do not think we do have that ability to put conditions on what they do or do not do. What Ms Shakespeare was talking about was the arrangements that we have where we are funding the rural clinical schools where we do have the capacity to put that obligation for a 25 per cent intake of rural students, whereas the proposal from Curtin at the moment does not include a rural clinical school component, as I understand it.

Senator DI NATALE: I understand the logic. It just seems a bit strange to me that we would reduce the rural intake. Let me ask about the training positions. Are those guaranteed training positions internships?

Ms Shakespeare: The WA government has committed to provide the necessary additional internships.

Senator DI NATALE: What about post-internship?

Ms Shakespeare: And specialist training positions.

Senator DI NATALE: So all those specialist training positions will be available for graduates of Curtin or for all medical schools?

Ms Shakespeare: For all medical schools.

Senator DI NATALE: If you are in WA now and you are a graduate of one of the three medical schools, you have a guaranteed internship and a guaranteed specialist training place?

Ms Shakespeare: The guarantee is that the current commitments to medical students in Western Australia will continue, and they have committed to provide the additional internship and postgraduate training positions on top of that.

Senator DI NATALE: For all three medical schools? I just want to make sure I am not misunderstanding what you are saying. If you are a medical student at one of those three medical schools, you have a guaranteed placement as an intern, and then post internship in a specialist training program?

Ms Shakespeare: The wording of the commitment is that the existing students, as they are catered for in Western Australia, will continue and on top of that, the WA government committed to provide the additional clinical training and supervision support, additional internships and additional specialist training places.

Senator DI NATALE: How is that different to what I have said?

Ms Shakespeare: I am just making sure there is no misunderstanding.

Senator DI NATALE: That is what I am trying to do, which is why I framed it in that way. If the way I had presented it is different from the way you understand the agreement, can you just explain to me the differences?

Ms Shakespeare: It might be better to get the Western Australian government to discuss or provide advice to you about its current commitments to existing students in WA.

Senator DI NATALE: I am not going to waste time, because I know we are short of time. But it is a pretty straightforward question. With respect to the maldistribution issue, I note that the Prime Minister said that 38 per cent of doctors are overseas trained in WA. Is the implication there that there is a shortage of medical graduates in Western Australia? Is that the implication of those comments?

Ms Shakespeare: Overall the number of doctors per head of population in Western Australia is much lower than in the eastern states, places like New South Wales and Victoria. When you look at the national average, there are fewer doctors per head of population in Western Australia. I suppose other evidence we have indicates that people are more likely to continue working in places where they train, so that would be the expectation. By training more medical students in Western Australia, they are more likely to remain working there once they graduate.

Senator DI NATALE: There is obviously a big maldistribution issue in WA as well, is there not?

Ms Shakespeare: Yes.

Senator DI NATALE: Having fewer students from a rural background means that it is likely that we will see fewer of them practising in rural and regional areas as well, does it not?

Ms Shakespeare: I do not think you will see fewer students from a rural background. In addition to the two medical schools in Western Australia that currently participate in the rural clinical schools program are required to have 25 per cent of all of their medical students from a rural background, and 25 per cent training for 12 months in a rural clinical area. There will be an additional 20 per cent of the Curtin intake at this stage—and that may increase should they participate in the rural clinical schools; that has not been decided yet—on top of those from a rural background training in future. That to me sounds like an increase.

Senator DI NATALE: It is an increase, but again it is 20 per cent compared to 25 per cent, so we are arguing about the different proportions, are we not?

Ms Shakespeare: But it is additional.

Mr Bowles: It is proportional if you look at it in individual things, but we are talking about an overall increase of which 20 per cent is on top of the other two 25 per cents.

Senator DI NATALE: Sure.

Senator CAROL BROWN: Is not the difference also that the 20 per cent target, which I understand Curtin has indicated it wants to take up to something like 50 per cent, is self-funded, whereas under the rural clinical schools program, the 25 per cent is federally funded.

Ms Shakespeare: Yes.

Senator DI NATALE: I am done with the medical schools, thank you.

Senator McLUCAS: I want to refer to the modified Monash model. When will the modified Monash model commence operation?

Ms Shakespeare: The modified Monash model has already commenced operation. It was applied to the Bonded Medical Places Program from, I think, 31 October last year. In addition to districts of workforce shortage, bonded medical graduates could also do their return of service obligation in modified Monash categories 4 to 7. Since then, the government has announced that that will also be applied to the general practice rural incentive program and there may be other programs that will be examined on a case-by-case basis that are moved to the modified Monash model over time.

Senator McLUCAS: So there are some programs that are using the old ASGC-RA?

Ms Shakespeare: Yes.

Senator McLUCAS: We cannot say ARIA, can we, because that is the one before, is that right?

Ms Shakespeare: There is RA, and some programs use another one called RRMA. There are still multiple systems in place.

Senator McLUCAS: Are you still using RRMA?

Ms Shakespeare: It depends on the program.

Senator McLUCAS: So there are only those two programs that are using modified Monash at the moment?

Ms Shakespeare: The government has also announced that the Dental Relocation and Infrastructure Support Scheme will move to the modified Monash model, but that does not happen until next year.

Senator McLUCAS: Is it intended that, over time, all programs will move to using modified Monash?

Ms Shakespeare: We need to examine each program to see whether it is appropriate to move it to the modified Monash model. It has been developed in the context of looking at population, size of towns as well as remoteness. There may be some programs where that is less relevant, so we do need to look at each program.

Senator McLUCAS: You will test whether or not there are unintended consequences that will flow?

Ms Shakespeare: That is right.

Senator McLUCAS: Have you done any work on which ones where modified Monash might not work?

Ms Shakespeare: We have people looking at a range of programs at the moment, but I do not know that I could provide you with that advice at this point.

Senator McLUCAS: Do you intend to go through all of the programs just to see which is the best fit?

Ms Shakespeare: Yes, where there is a rural element that we need to measure.

Senator McLUCAS: We will come back to that at the next estimates. By that stage I think you will probably have done more work there. I am not making any assertion that you are not working hard enough now. Have the final boundaries of the new geographical classification areas been drawn on a map?

Ms Shakespeare: We do have a searchable map facility available now, which is on the Rural Health Australia website.

Senator Nash: Which is the DoctorConnect.

Ms Shakespeare: We still have DoctorConnect. Because the GP RIPs changeover does not happen until later in the year we still have access to the RA maps and the DWS maps on DoctorConnect, but we will move over once the program has transitioned.

Senator McLUCAS: Is it clear to people who are interested in the different ways these mapping systems are applied that each program is using a different mapping system?

Ms Shakespeare: We think that it is. We certainly have material on our websites that explains what the different classification systems are used for. We have prompts when people are searching by districts of workforce shortage, for instance, to remind people that this is just relevant in this map for GPs. It will be similar for the modified Monash model. We will have contextual information on the website explaining what the particular classification system relates to.

Senator McLUCAS: In terms of the application for area of district workforce shortage, did you say that that has moved to modified Monash yet?

Ms Shakespeare: No, they are quite different classification systems. They will both be available through the websites that we operate, and people can tick boxes to apply different layers. If they are interested in looking at whether or not an area is a district of workforce shortage, they can tick that search facility. Otherwise they can search by RA or modified Monash model.

Senator McLUCAS: Is there a document that you can provide us that basically overlays the ASGC-RA with modified Monash in a visual form?

Ms Shakespeare: Yes, certainly there are maps, but if you put it on a page, most of the detail is actually around the capital cities, which is where you have most of the population. We can certainly provide it. You will probably get better information using an interactive tool and looking at the map. It allows you to zoom in and out of particular locations.

Senator Nash: If it assists, the other thing we might provide you with is the comparative tables of how it looked under the ASGC-RA and then the new table of the modified Monash model and the categories that swap over to that, because that is quite a useful comparative table.

Senator McLUCAS: Where do I find that?

Senator Nash: We will provide that for you.

Senator McLUCAS: Can you indicate just for the purpose of having the conversation which towns and potentially cities based on the current system will move? I am talking mainly about Cairns and Townsville, but I am sure there are more.

Ms Shakespeare: There are 447 towns that will receive higher incentives, and I can provide a list of those, or read them out, but it would take a long time.

Senator McLUCAS: No.

Ms Shakespeare: We have large towns that lose incentives under the modified Monash model.

Senator McLUCAS: How many of those?

Ms Shakespeare: Fourteen. Then I think there are 20 locations that receive reduced incentives.

Senator McLUCAS: So 14 large towns and six cities?

Ms Shakespeare: It depends on how you define cities. These are just large towns with populations over 50,000.

Senator McLUCAS: Could you just read out those 20?

Ms Shakespeare: These are the 14 that lose incentives.

Senator McLUCAS: I thought you said there were 20 that lose incentives.

Ms Shakespeare: Twenty will receive a reduced or potentially reduced incentives, and 447 that will receive higher incentives.

Senator McLUCAS: Okay. When you say lose, like no incentive?

Ms Shakespeare: That is correct.

Senator McLUCAS: Essentially they are treated as a metropolitan area?

Ms Shakespeare: They are a modified Monash category 2, so a town with a population of above 50,000.

Senator McLUCAS: Do not read them out. We can work that out. Could you provide that on notice with the 447 who get a higher incentive, please?

Ms Shakespeare: Yes.

Senator McLUCAS: But the six that get a reduced incentive—let us understand that a bit better.

Ms Shakespeare: Under the GP Rural Incentives Payment Schedule, there are some locations which are currently in RA3 that will become modified Monash category 3. Depending on the length of time a doctor has been working in that location, they may receive slightly lower incentives under the new scheme. But again, it would depend on how long a doctor has been working in a particular area, because the incentives are increased and scale up over time.

Senator McLUCAS: Could you either point us to a place where that is explained or identify on notice?

Ms Shakespeare: I think we would need to take it on notice as well.

Senator McLUCAS: What the six reduced access items are. They will reduce over time, but do those six locations end up in with the 14 large towns?

Ms Shakespeare: No. They would be modified Monash category 3, not modified Monash category 2.

Senator Nash: Can I just clarify, because I think we are getting a bit of 14 and 6 and 20 happening here. There are 14 that will get no incentive. If I am right, there are 20 with reduced incentives. I think you were adding those two together to get to the 20.

Senator McLUCAS: So 20 with reduced and 14 that are large towns.

Senator Nash: Those 14 will cease to get payment and get nothing.

Senator McLUCAS: Can you provide a table listing each of the towns, their state, their electorate—I do not know if you would have that information?

Ms Shakespeare: We can certainly provide town and state.

Senator McLUCAS: Its current ASGC-RA classification and its new MMM classification—that table is reasonably easily provided?

Ms Shakespeare: Yes, except that we cannot do by electorate.

Senator McLUCAS: That is fine. If you cannot do it, you cannot. Are you able to provide a summary of each of the incentive payments available under the GP RIP and other programs for each classification?

Ms Shakespeare: Yes, but again there are different amounts, depending on length of time. So it gets confusing. I can read it out to you. But again, it might be better if we give it to you in a table.

Senator McLUCAS: If you can provide that on notice, thank you. The final question you might not be able to answer: what programs will be impacted by the change of geographic classifications? I think you have probably answered that in the bonded scholarships, the GP rural incentives and the dental relocation; is that all?

Ms Shakespeare: At this stage, yes.

Senator McLUCAS: I have one more question that goes back to Senator Brown's line of questioning. How does a student withdraw from the Bonded Places Scheme, and what are the costs of doing that for the student?

Ms Shakespeare: In withdrawing, there is a certain proportion of the costs of the Commonwealth Supported Medical Place that need to be repaid, but I do not have the information on exactly how much that is. The amount of money will depend on the length of the course, I expect, as well. We can take that on notice.

Senator McLUCAS: That would be great, thank you.

Senator CAROL BROWN: I just want to confirm what I think you told me earlier. The Puggy Hunter Memorial Scholarship program is going into the one consolidated program, but it will be branded exactly the same?

Ms Shakespeare: Yes.

CHAIR: I was a little bit distracted for a few moments there, notwithstanding the riveting nature of the questioning and the evidence. I was not sure whether or not the issue around Specialist Training Program had been covered off. Did I miss some questioning around that?

Dr Southern: No, I do not think we have done the Specialist Training Program yet.

CHAIR: I have a couple of brief questions before we move to Population and Health. I know it will be extended for a further 12 months, but is someone able to outline for me what the effect of that extension will be? I will then have a couple of follow-up questions.

Ms Shakespeare: The extension for the 2016 training year means that the current 900 full-time equivalent specialist training positions will be continued for another training year. That will be through existing allocations to the various specialist medical colleges.

CHAIR: I am not really familiar with this program. What sort of advantages are provided to trainees through this program?

Ms Shakespeare: The program itself represents between five and seven per cent of total specialist training that occurs in Australia. Most of the training actually occurs in public hospitals. However, this program supports a diversity of training environments for specialist registrars. It supports training in private hospitals; it also supports training in community settings and in rural and regional hospitals.

CHAIR: What kinds of specialties are covered under the program?

Ms Shakespeare: We currently have funding agreements under STP and its related emergency medicine program, with 13 different specialist colleges. There is a fairly wide range: psychiatrists, emergency medicine, physicians, and there are a lot of different

subspecialties under physician training, medical administrators, sports and exercise positions—the full range—dermatologists.

CHAIR: Is it all rural and regional, or just predominately—

Ms Shakespeare: No. We have quite a few training places in rural and regional, but there are also quite a lot of training posts supported through this program in metropolitan areas.

CHAIR: Do we see many of them coming through here in Canberra?

Ms Shakespeare: I will just see if I have my state breakdowns. In 2014, which is the last year for which I have accurate data, in the ACT there was a total of 11 funded posts.

CHAIR: Do you have a breakdown of some of the specialties with those 11?

Ms Shakespeare: Yes. There was one in dermatology, four physicians, one in surgery, three psychiatrists, one radiologist, and it looks like one in pathology.

CHAIR: Thank you very much, I appreciate that. That brings us to an end of outcome 8. We will now move onto outcome 1: Population and Health. Senator Leyonhjelm.

[17:25]

Senator LEYONHJELM: I have some questions in relation to the plain packaging policy. Has the department sent a draft post-implementation review of plain packaging to the Office of Best Practice Regulation?

Ms Flynn: No, we have not sent it to the OBPR as yet. It is due by 30 June.

Senator LEYONHJELM: It is going to cost, I think from previous questioning, $3 million, is that correct?

Dr Southern: The cost of the post-implementation review?

Senator LEYONHJELM: Yes.

Ms Flynn: I have the total value of the contract as $484,879.35.

Senator LEYONHJELM: The Office of Best Practice Regulation told Senator Bernardi recently that it often rejects post-implementation reviews on the basis of unsound methodology. What steps do you anticipate will be taken if that feedback comes back from the Office of Best Practice Regulation?

Mr Bowles: I think that is a bit of an assumption at this stage, given that we have not even finished the post-implementation review, and it will go to OBPR after 30 June.

Senator LEYONHJELM: Why was the methodology not presented to the OBPR before it was commenced?

Dr Southern: My understanding is that there were discussions with OBPR about the post-implementation review and we have had those conversations over the last little while and before we went out with the review.

Senator LEYONHJELM: It appears from the May estimates hearing that the OBPR has no knowledge of the post-implementation review on this issue.

Dr Southern: I do not think I would have read that as saying they had no knowledge of it. Certainly they indicated that there was a post-implementation review underway, that they were aware of that, and were expecting it by June. As I said, my understanding is that we have had discussions at officer level with OBPR as we have prepared for the PIR.

Senator LEYONHJELM: Do you think the fact that the objective of the Plain Packaging Act and the objective of the post-implementation review differ will affect the OBPR's assessment?

Dr Southern: I do not think it would be correct to say that the post-implementation review objectives differ from the objectives of the act. I think we had this discussion in part at the last Senate estimates. If we go through the consultation documentation which is being used at the moment for the PIR, the introduction section of that documentation summarises the objectives of the tobacco plain packaging measure, and it uses the words from subsection (3)(1) of the act, which is the part of the act that sets out the objectives of the act. It also uses language from subsection (3)(2) of the act and from the explanatory memorandum. Then as we go through the questions which are actually put to stakeholders in the PIR documentation, some of the questions address the objectives in paragraph (3)(1)(a) of the act, and some of the questions address subsection (3)(2). I think our view is that the consultation documentation certainly covers off the objectives of the act.

Senator LEYONHJELM: What significance do you place on the explanatory memorandum?

Dr Southern: All legislation, as you would know, when it is introduced into parliament is accompanied by an explanatory memorandum which seeks to provide information to the parliament about the objectives of particular pieces of legislation and how they will operate. So it is an important part of a legislative package.

Senator LEYONHJELM: Once an act is in place, what use is there of an explanatory memorandum?

Dr Southern: I still think they are very useful reference documents to go back to.

Senator LEYONHJELM: Is the objective of the post-implementation review to assess its impact on the primary objectives of the Tobacco Plain Packaging Act, which is reducing the prevalence of smoking?

Dr Southern: As I said, the post-implementation review is to look at the broad impact of the tobacco plain packaging measure. It is to assess whether a regulation or a piece of legislation remains appropriate, and how effective and efficient the regulation or legislation has been in meeting its objectives. In referring to the objectives of the act, if we go to section 3, and as I said, the consultation documentation covers off on those aspects of the objectives of the act.

Senator LEYONHJELM: The objectives of the act say that they are to: 'improve public health by discouraging people from taking up smoking, encouraging people to give up smoking, discouraging people who have given up smoking from relapsing, reducing people's exposure', and to give effect to certain obligations. Under the Siggins Millar post-implementation review, it says, 'The objectives of the tobacco measure are to regulate the retail packaging appearance of tobacco products in order to reduce the appeal of tobacco products, increase the effectiveness of health warnings, and reduce the ability of the retail packaging to mislead consumers.' In the post-implementation review, are you actually going to review its impact on smoking?

Dr Southern: I think, if you go on with the text of the Siggins Millar consultation paper as you just read out, it talks about the measures that you just talked about, and then it goes through and says:

Through the achievement of these objectives in the long term as part of a comprehensive range of tobacco control measures, contribute to efforts to improve public health by discouraging people from taking up smoking or using tobacco products, encouraging people to give up smoking and to stop using tobacco products, discouraging people who have given up smoking or who have stopped using tobacco products from lapsing and reducing people's exposure to smoke from tobacco products.

That repeats the language of the objects of the act. It is all there in the Siggins Millar document.

Senator LEYONHJELM: In 2012, prior to the implementation of plain packaging, Senator Fierravanti-Wells was asking a question of your department and a Mr Smyth answered:

In relation to determining the effectiveness of the proposed legislation at that time the key survey we will be looking at is the one I just mentioned from Cancer Council Victoria and it would be a systematic survey of existing smoking habits and then the habits of people's purchasing choices, et cetera, post that as well.

What happened to that?

Dr Southern: What happened to what?

Senator LEYONHJELM: That survey.

Dr Southern: The survey has been undertaken and earlier this year the Cancer Council published a series of papers in the *British Medical Journal* which report on its analysis of some of that survey work.

Senator LEYONHJELM: Has any of that work been repeated post plain packaging?

Dr Southern: Yes. As I understand it, the survey was undertaken in the period after the legislation was introduced.

Senator LEYONHJELM: What did it show?

Dr Southern: As I mentioned, the Cancer Council published much of its research in relation to those surveys earlier this year. There was a special supplement of the *British Medical Journal* published on 19 March which contained 15 peer-reviewed articles which outlined the results of that research.

Senator LEYONHJELM: Did it show a reduction in the prevalence of smoking post plain packaging implementation?

Dr Southern: I have quite a bit of information on various bits of research here. I am fairly confident that the research certainly indicated that the prevalence had reduced. I just cannot put my hands on the outcome of that research here, so we will take that on notice for you. The publications are freely available.

Ms Flynn: The Department of Health commissioned the following pieces of research work which have formed the basis for this series of articles: 'The National Monthly Tobacco Plain Packaging Tracking Survey', 'Evaluation of the early effects of Tobacco plain packaging on adolescents' and 'Research relating to Australian cigar smokers'. On the first element, the National Monthly Tobacco Plain Packaging Tracking Survey, in April 2012 the Department

of Health contracted the Centre for Behavioural Research in Cancer at Cancer Council Victoria to conduct a national cross-sectional monthly tracking survey of smokers and recent quitters for the purpose of assessing the short- to mid-term effects of the tobacco plain packaging. Between April 2012 and March 2014 400 smokers and recent quitters were surveyed every four weeks. The survey included a mix of the population from urban, rural and remote locations from all Australian states and territories.

The key findings in the tracking survey include the reduced appeal of cigarette packs, increased effectiveness of health warnings, some improvement in correcting misperceptions of harms and increased rates of attempts to quit. The survey also found that the objectives of the tobacco plain packaging were achieved and sustained among adult smokers up to 12 months after implementation.

With 'Evaluation of the early effects of tobacco plain packaging on adolescents', the Centre for Behaviour Research in Cancer at the Cancer Council Victoria conducted a follow-up survey in 2013 of students attending secondary schools in Victoria and Queensland that participated in the 2011 Australian Secondary Students Alcohol and Drug Survey. The 2013 evaluation survey was designed to compare attitudes to cigarette packaging before and after the introduction of tobacco plain packaging. The evaluation survey included questions about beliefs and attitudes about cigarette packagings, ratings of popular cigarette brands, noticing health warnings on cigarette packs, awareness of the specific health harms of tobacco use, perceptions of the prevalence of smoking and intention to smoke. The evaluation survey found that the appeal of cigarette packs and brands to Australian adolescents had decreased significantly.

The third element, 'Research relating to Australian cigar smokers', conducted by the South Australian Health and Medical Research Institute, aimed to explore the experiences of cigar and cigarillo smokers under tobacco plain packaging. The cigar research concluded that non-premium cigarillo smokers appear to have been most exposed to and influenced by tobacco plain packaging.

Senator LEYONHJELM: Just in case I missed it, did it conclude the prevalence of smoking had declined?

Ms Flynn: It was designed to measure the impacts of the tobacco plain packaging measure.

Senator LEYONHJELM: Indeed, and the objectives of that act are to reduce the prevalence of smoking. Did that work find that it achieved that objective? I do not think I heard you say that, but perhaps I missed it.

Ms Flynn: I am just looking for the latest.

Dr Southern: The summary that I have here indicates the key findings from the tracking survey, which was the tracking survey that was conducted between April 2012 and March 2014, where 400 smokers and recent quitters were surveyed every four weeks. It found that the objectives of tobacco plain packaging were achieved and sustained among adult smokers up to 12 months after implementation, but I would need to go back to the actual journal articles to provide you with further detail.

Ms Flynn: There was certainly an increase in smokers trying to quit.

Senator LEYONHJELM: There is quite a lot of associated information but the objective of the act, as it says, is to reduce the prevalence of smoking. I do not think that was confirmed in those series of surveys of the Cancer Council, which leads also to the question: is that the primary objective of the Siggins Millar postimplementation review, to determine whether that object of the act has been achieved?

Dr Southern: As I mentioned earlier, the questions in the consultation documentation go to all aspects as set out in section 3 of the objects of the act, so they will address each of those objects. I certainly think that in discussing the outcomes of the tracking survey and the Cancer Council research we have pointed to evidence around encouraging people to give up smoking, to stop using tobacco products, intention to give up and to prevent people from relapsing. There was also evidence in at least one of the papers which went to the issue of reducing people's exposure to smoke from tobacco products in that it looked at the propensity of people to smoke in public. I think there certainly is a range of evidence that comes out of that research which goes to the objects of the act.

Senator LEYONHJELM: There is lots of evidence. I guess the question is the act has quite specific objectives relating to the prevalence of smoking. The objectives of the survey, the Siggins Millar postimplementation review process, are to address issues relating to the appeal of tobacco products, the effectiveness of health warnings about retail packaging and misleading consumers. What I want to know is: will it determine whether prevalence of smoking has changed?

Dr Southern: That is certainly the intent of the consultation documents. I read out to you earlier the part of the consultation document which goes to exactly those things. Yes, it covers off information about reducing the appeal of tobacco products to consumers and reducing the ability of retail packaging of tobacco products to mislead consumers, but it goes on in that same part of the document to talk about the objectives around improving public health by discouraging people from taking up smoking and so on.

Ms Flynn: Could I also say that it will take into account some recent research by the AIHW. In November 2014 they released a report called *The 2013 national drug strategy household survey detailed report*. That report shows that daily smokers aged 14 years and older in Australia declined from 16.6 per cent in 2007 to 15.1 per cent in 2010 and 12.8 per cent in 2013. Daily smokers aged 18 years or older declined from 17.5 per cent in 2007 to 15.9 per cent in 2010 and 13.3 per cent in 2013. Other findings included that young people are delaying commencing smoking. The average age at which 14 to 24-year-olds smoke their first full cigarette increased from 15.4 years of age in 2010 to 15.9 years of age in 2013.

Mr Bowles: I can add to this conversation. The PIR has not finished. It will finish and it will go through the normal process. I just want to point out that none of this is about short-term measures. Tobacco is a very highly addictive substance and it does take time for people to quit. This is a long-term health strategy that we are talking about and you do not necessarily see immediate results. I think there is a lot of evidence about the highly addictive nature of tobacco and the fact that it does take time to quit. This being a long-term public health measure, it is in the interests of the community and we will continue with the current PIR and we will continue with the process around that.

Senator LEYONHJELM: The plain packaging legislation has wiped out intellectual property worth billions of dollars. If that is going to be justified in a public interest sense then

it needs to be, at the very least, achieving its objectives. Now, it seems to me that the PIR could find that the appeal of tobacco products to consumers has been reduced, that the effectiveness of health warnings in terms of being noticed or remembered or something like that has gone up, that fewer consumers are being misled about the harmful effects of smoking, and yet the prevalence of smoking has not altered one scrap.

Mr Bowles: I disagree with that. I think we have just heard some statistics that smoking is at an all-time low at 12.8 per cent.

Senator LEYONHJELM: That is true but it was declining before the plain packaging was implemented.

Mr Bowles: Can I finish?

Senator LEYONHJELM: Yes.

Mr Bowles: We are still in this process. As I said, this is a long-term health strategy trying to tackle a highly addictive substance like tobacco. We will continue with the PIR. It will be completed by the end of June and we will determine what happens from there. We cannot move away from the long-term health impact that this will have. We are seeing rates come down. We will continue, I am sure, to see rates come down, and that is where we are up to with this particular topic at the moment.

Senator LEYONHJELM: Rates of smoking were falling before plain packaging was implemented. The issue is whether this act has reduced the prevalence of smoking. That is the issue.

Mr Bowles: We need to wait until the outcome of the PIR. If you want to pursue that line we should wait until we have the outcome of the PIR.

Senator LEYONHJELM: Except that the Office of Best Practice Regulation has not seen it and they say, in answer to questions from Senator Bernardi, that frequently PIRs are rejected.

Mr Bowles: They have not seen our PIR. It is not due to them yet. Until they see it and until they reject it we should not have that conversation.

Senator RUSTON: Obviously your measurement is on legal tobacco. How do you measure illegal tobacco in this space?

Mr Bowles: In what way?

Senator RUSTON: You have quoted the—

Mr Bowles: No. We are talking about smoking rates broadly.

Senator RUSTON: So, how do you measure illegal tobacco and illicit tobacco, whether it be chop chop or whether it be a branded product that is being imported? How do you measure that?

Ms Flynn: There are questions asked about illegal tobacco in the National Drug Strategy Household Survey. They do come to that question.

Senator SMITH: Is it not part of the PIR?

Ms Flynn: It is an AIHW survey that would be taken into account as part of the PIR.

Senator RUSTON: It is just that the KPMG's report on tobacco consumption in Australia suggests that consumption has stabilised as opposed to going down; it is just that we have had a transference from legal sales to illicit.

Mr Bowles: I do not know where you are getting that from.

Senator RUSTON: It is the KPMG, *Illicit tobacco in Australia*. I assume you would have seen this.

Dr Southern: As I understand it, they talk about 13.5 per cent illicit tobacco in 2013-14 and 14.5 per cent in 2014, but we have concerns about the methodology used in the KPMG report. I think in estimates last week when the Customs and Border Protection Service was appearing before the Senate estimates committee the CEO also expressed some concerns about the methodology.

Senator RUSTON: What is your methodology for determining that?

Dr Southern: We use the survey that Ms Flynn mentioned which talked about people responding to questions about the use of illicit tobacco. Those figures were somewhat less, around three or four per cent.

Senator RUSTON: Do you have any idea how easy it is to actually buy it?

Dr Southern: I have never tried.

Senator RUSTON: I have. You can walk into the average supermarket in most streets and ask for cheap cigarettes and get them. I am sure there are a lot of smart people who have worked that out, given the cost of cigarettes.

Mr Bowles: Like the e-cigarettes. I hope you report them to the police as well.

Senator RUSTON: Indeed.

Mr Bowles: Basically that is an illegal activity.

Senator RUSTON: I am just asking, because as Senator Leyonhjelm said, we want to get a handle on whether these initiatives are really working. I, as much as anybody else, would like to see people not smoking, but it just seems to me that the illicit cigarette market seems to have got a hold of us and we are not actually taking that into account.

Mr Bowles: I do not think there is any evidence to suggest that.

Senator RUSTON: I hope you are right.

Mr Bowles: As Dr Southern said, that is not the evidence that has been put in by Customs and Border Protection. Let me say that I think there is a bit of an overplay on some of this by interested parties.

Senator RUSTON: I am not particularly interest in—

Mr Bowles: I was not referring to you. I just hope you report them to the police when you do find this.

Senator LEYONHJELM: What good would that do? It is a massive industry.

Mr Bowles: You should report it to the police.

Senator LEYONHJELM: It is a massive industry. Can I pursue this line of questioning a little further? I would like you to satisfy me that my concerns are unfounded. I am concerned that you have made up your mind that plain packaging was a good policy decision and you

are prepared to defend it irrespective. How will you be able to satisfy me that the rate of smoking was not falling anyway and would not have continued to fall irrespective of plain packaging and that plain packaging actually has contributed to that rate of fall of smoking?

Mr Bowles: All I will say is that the PIR is not finalised and, as I have said, tobacco is a highly addictive substance. This is about a long-term health strategy and, to be frank, we need to do as much as we can to reduce smoking rates and we will continue to do that. That is part of our broader health strategy.

Senator LEYONHJELM: That is a policy decision. That is a matter for government to do as much as possible. If as much as possible includes wiping out the intellectual property of legal products then I think that 'as much as possible' might be going a little bit far, especially if you cannot objectively demonstrate—not start with a conclusion and work back—on data that the measure that wiped out so much intellectual property actually achieved its aims.

Mr Bowles: My job is about the long-term health of the Australian community. We will continue to do what we need to do and that is where we are. As I keep saying, it is a highly addictive substance.

Senator LEYONHJELM: So, you are not really interested in satisfying my question as to whether the plain packaging objectively achieved its aim?

Mr Bowles: You seem to be making inferences about our objectives here in what we are doing. That is not fair and it is not true.

Senator LEYONHJELM: I am asking you to satisfy my concerns. That is what I am asking.

Mr Bowles: And we are undertaking the PIR at the moment. It is not finished at this particular stage.

Senator LEYONHJELM: Are you comfortable that it will show that, independently of all other variables, plain packaging contributed to a reduction in the prevalence of smoking?

Ms Flynn: We have prevalence data going back to 1991. You are certainly correct in saying that smoking has been decreasing over that period, but in the time frame 2010 to 2013 there has been an increase in the decrease. It is decreasing more rapidly than it has over the years back to 1991.

Senator LEYONHJELM: I am going to leave it there. This is an issue obviously of significant importance, as I said, not because I am a smoker. I will never report somebody selling a product which is legal to consume but billions of dollars of intellectual property have been wiped. If there is not a good public interest outcome, which would be a very substantial reduction in smoking—and I think that would be a good public interest outcome—if you have not achieved a good public interest outcome then it is a failed policy. That is the conclusion that is unavoidable. There is no point in saying, 'We'll do everything we can to wipe out smoking', if it has not achieved it. All I am doing is putting on notice that this is an interest of substantial public importance and I will be following it up.

Senator McLUCAS: I would first of all like an update on the healthy food star rating process. How is that going?

Ms Flynn: At the last count there are about 500 products in the marketplace that are carrying the stars. In grocery retail areas they also talk about SKUs, stock keeping units. If

you think about Weetbix, it is one product that the 500 gram is one SKU and the one kilogram is another SKU. There are 650 SKUs carrying the star, or around about 500 products.

Senator McLUCAS: Do you have the data on the number of companies who have engaged?

Ms Flynn: It is around about 40 now, and increasing.

Senator McLUCAS: How is the use of the website going?

Ms Flynn: I do not have the website statistics with me, but I can take that on notice.

Senator McLUCAS: I am very interested in who is using the website. You probably cannot answer that.

Ms Flynn: We know the hits but we do not know who is doing the hits.

Senator McLUCAS: Was it by and large designed for the manufacturers?

Ms Flynn: Yes.

Senator McLUCAS: Have you had much consumer feedback?

Ms Flynn: It is purely anecdotal at this stage. We have heard, for example, that children are picking up on the stars and looking for a greater number of stars, but that is anecdotal at this stage.

Senator McLUCAS: Minister, have you been in touch with your former chief of staff recently?

Senator Nash: No.

Senator McLUCAS: Not at all?

Senator Nash: No, not at all.

Senator McLUCAS: You have not met him socially?

Senator Nash: No.

Senator McLUCAS: Since he left your office?

Senator Nash: No.

Senator McLUCAS: Are you aware that he works for two different lobbying firms?

Senator Nash: No.

Senator McLUCAS: Are you aware that he is not a person who is listed on the lobbyists register?

Senator Nash: No.

Senator McLUCAS: Thank you.

Senator MOORE: I note Cancer Australia are here and need to get back to Sydney. I have some questions for them. Would it be okay to go there?

Cancer Australia

[18:00]

CHAIR: We invite Cancer Australia to the table. Senator Xenophon.

Senator XENOPHON: I have questions in relation to the National Bowel Cancer Screening program. It relates to an issue raised by a constituent. I note that it provides free

test kits for the detection of bowel cancer to men and women aged 50, 55, 60, 65, 70 and 74. I understand that Dorevitch Pathology carries out tests on behalf of the government. Other companies also use bowel cancer screening; however, this is on a user-pays basis. A constituent has recently contacted me with concerns about different faecal occult blood test, FOBT, results that came from the NBCSP and a private company who have both been provided with samples from the same faecal specimen. The NBCSP FOBT results stated no blood was detected in the sample whereas the private company's results reported that the blood was detected, which caused some distress to the constituent. He was advised that it was possible exposure to heat during transport may have caused the variation in results. The broad question that I am happy for you to take on notice is: what transport policies are used by the department for NBCSP samples, specifically what steps does the department take to minimise heat exposure of samples and has there been a review of the current government's NBCSP test and its accuracies compared to other bowel screening tests currently on the market and recommended by the Cancer Council?

Dr Southern: We probably will need to take that one on notice. I think you have the record for speaking faster than anyone.

Senator XENOPHON: I am conscious of the committee's time. Senator Dastyari can sometimes beat me at it, which is saying something. My fourth question, which I am happy for you to take on notice, is: why did the government choose this type of test over other types of tests available? Fifthly, I understand the FOBT offered by ColoVantage is stable for 14 days up to the temperature of 37 degrees Celsius. Does the NBCSP FOBT have the same stability?

Dr Southern: I will take that one on notice.

Senator XENOPHON: I thank my constituent who did a lot of research on that.

Dr Southern: Absolutely.

Senator XENOPHON: And good on him. These are genuine issues. To get a false positive—

Dr Southern: I know they are.

Senator XENOPHON: Obviously it can be quite distressing. I suppose a false negative is even more concerning.

Dr Southern: Yes. There are some technical details there that we will follow up and respond to on notice.

Senator XENOPHON: Thank you.

Senator MOORE: I cannot guarantee to be as quick as Senator Xenophon. We will just do some and if I do not have enough time I will put them on notice. I would like to get an update on what consumer information Cancer Australia is currently producing. I have seen the website. I just want to double check what the consumer focus is on.

Prof. Zorbas: We have a comprehensive website and we are currently looking at ensuring that all the information is current. There is quite a strategy around having fact sheets on all the common cancers as well as data. There is also information around risk factors, symptoms, appropriate testing and treatments for cancer. We have a particular piece of work that we are currently undertaking in relation to childhood cancers. This is a subsite, if you like, of our

website. That work is currently complete and is due to be released within the next few months. It provides information around childhood cancers and is specifically focused for not only children affected but particularly their families and health professionals who care for them.

Senator MOORE: Your website sets out the key areas in terms of the focus. Do you keep monitoring on the usage of that website because just about everything is downloadable?

Prof. Zorbas: Yes.

Senator MOORE: Do you get an idea about what are your best sellers and what people are asking for?

Prof. Zorbas: We certainly do. I can give you that in a moment. Over 95 per cent of our resources that are downloaded and sought in hard copy are consumer information and resources. We ensure that we maintain those as being up to date. We have about 2,000 pages of content and 500 resources on our website. The key resources that consumers are requesting are: Guide for Women with Early Breast Cancer; Lymphoedema: what you need to know; Cancer: how are you travelling?—that is really around the journey of the psychosocial impact of cancer—What is your cough telling you, which is around the symptoms of lung cancer; and Have you done your cheeky check-up, which is about breast awareness in terms of symptoms of breast cancer. We also have clinical resources which continue to be popular in relation to breast cancer, psychosocial care and gynaecological cancer.

Senator MOORE: Are they directed towards practitioners?

Prof. Zorbas: That is correct. They are clinical resources.

Senator MOORE: Can you provide us with an update on the invitations campaign through BreastScreen Australia?

Prof. Zorbas: That is a campaign that has been managed through the Department of Health.

Senator MOORE: Through the department?

Prof. Zorbas: Yes.

Senator MOORE: Can I get an update on the invitations campaign through BreastScreen Australia?

Dr Southern: The campaign has been extended recently. The original invitation was extended to people from 50 to 69 and that has recently been extended to women up to 74 years of age. The free breast screen was always available for women of that age but there was no actual physical invitation, if you like. The advertising campaign around that was launched in the last few weeks and the program is rolling out now.

Senator MOORE: What is the system for seeing how successful it is in terms of following up? Is there a link in to see whether women have actually responded to that invitation to go to BreastScreen?

Dr Southern: We will continue to gather the information about the rate of take-up, et cetera.

Senator MOORE: What is the time frame for the advertising campaign?

Mr Davey: The campaign was launched on 8 April and it is going to run until the end of this month.

Senator MOORE: So Breast Cancer Awareness month in May.

Mr Davey: It has been running since early April and it runs through to the end of June.

Senator MOORE: Can I put on notice how much that costs?

Mr Davey: You can. I can tell you now the media buy, which includes print, radio, online and out of home, is $1.65 million.

Senator MOORE: Is it nationwide?

Mr Davey: Yes.

Senator MOORE: Will there be an evaluation of that at the end?

Mr Davey: Evaluation research has already started. That will inform the next phase of campaigning.

Senator MOORE: Back to Cancer Australia; is your current staffing still 72 FTEs?

Prof. Zorbas: We had anticipated or projected an average staffing level of 72; however, we have now revised that to 68 for this year.

Senator MOORE: Is that the impact of the efficiency dividend?

Prof. Zorbas: It was more in relation to the current recruitment arrangements, the highly specialised staff that we require at Cancer Australia and you can appreciate a highly competitive market in Sydney also for those staff. We have made a business decision, if you like, to seek short-term contractors to deliver on our program of work; therefore, we have been able to ensure that we can deliver.

Senator MOORE: Does that mean that you are meeting your efficiency dividend requirements and adjusting work to that?

Prof. Zorbas: We are certainly meeting our requirements.

Senator MOORE: Can I also have an update on Cancer Australia's Priority Driven Collaborative Cancer Research Scheme? I am sure there is an acronym for that.

Prof. Zorbas: There is and it rolls off your tongue after you've said it 20 times. The Priority Driven Collaborative Cancer Research Scheme, fondly known as the PDCCRS, as you know is designed to fund collaborative cancer research projects in agreed priority areas. Through the 2014 round we were able to offer 25 applicants with grants. That was a total of $9.69 million. I think we had seven funding partners for that round. I could be corrected on that. Cancer Australia contributed $5.62 million to that total of $9.69 million.

Significantly, over the past four rounds funding partners and Cancer Australia have matched their contribution on a ratio of one to one, so we are able to increase the funding available to cancer research in Australia and expand the funding pool. We hope, through this year's round, to be able to continue that record. This year we have received a high number of applicants, with 436 compliant applications received, and they are currently being assessed by the NHMRC.

Senator MOORE: Do you have any idea when that will be announced?

Prof. Zorbas: It is typical to announce those grant recipients at the end of 2015, so probably around December.

Senator MOORE: When you were here last time we asked you about the link with the Medical Research Future Fund because at that stage the fund was being discussed. Have you had any ongoing links with the development of the Medical Research Future Fund through the research work that you do?

Prof. Zorbas: No. We have not been engaged in that process at all.

Senator MOORE: And there is no discussion in terms of where that money would go and possible interactions with the extremely successful rounds?

Prof. Zorbas: Not to date but that is not to say that we would not have some in the future.

Senator MOORE: Minister, is that still being considered? These are very similar questions to what I asked last budget in terms of the process. When we have identified the specific research model through Cancer Australia and the development of the Medical Research Future Fund, is it part of the ongoing discussion to see whether those things would be able to be looked at together? How is it going to work?

Senator Nash: I understand, but I will take it on notice.

Senator MOORE: I understand. It is very early in the process but I think it is really important. I am going to ask the same questions to the NHMRC.

Senator Nash: I am happy to do that.

Senator MOORE: In terms of the Jeannie Ferris Scholarship?

Prof. Zorbas: The Cancer Australia Jeannie Ferris Award process is in train and we have this year identified two fabulous recipients again. Those recipients have been advised that they are the successful recipients. One is a very prominent researcher and clinician and the other is a strong consumer advocate, a woman herself with gynaecological cancer. We have not, as yet, made the public announcement but we will be doing so this month.

Senator MOORE: So, by the end of June?

Prof. Zorbas: That is right.

Senator MOORE: You know that we actually had the launch of the Gynaecological Foundation very recently.

Prof. Zorbas: It was last week.

Senator MOORE: Does Cancer Australia have any link with that or is that just in terms of fellow travellers?

Prof. Zorbas: Not an official link at all; as you appreciate, it is newly established. However, we do liaise on a regular basis with key people within that organisation, particularly obviously Professor Neville Hacker who, as you would recall, was a recipient of our Jeannie Ferris Cancer Australia Award himself. We would hope through their fundraising activities to have some discussions with them around opportunities to direct some of that funding through the Cancer Australia PDCCRS program.

Senator MOORE: Which would tend to be the way that you look at finding partners with particular interests in the process.

Prof. Zorbas: Correct. The opportunities are there for fundraising or organisations and foundations who are funding cancer research to pool the money with Cancer Australia so that non-government and government funding can improve cancer outcomes together.

Senator MOORE: Can we get some information on notice in more detail around the Priority Driven Collaborative Cancer Research Scheme? You gave some really good information about partnerships and also the number of recipients this year. Can I get some more information of that kind on notice?

Prof. Zorbas: Certainly.

Senator MOORE: Thank you.

CHAIR: I have some good news or bad news, depending on how keen people are. I am told that outcome 9, Biosecurity and Emergency Response, will not need to join us after dinner. We are told there are no questions.

Senator McLUCAS: I do have questions but I am mindful of outcome 1. I promise I will ask you a question, professor, but my questions can go on notice. I thought if there were other staff who would like to go home, who only have responsibility in outcome 9, that provides them with the opportunity to do that.

Mr Bowles: If outcome 9 is going, do we want to get the sport people in earlier?

Senator McLUCAS: No, I am working on the basis that—

Mr Bowles: Are we going to use that two hours?

Senator McLUCAS: I think what we have got in the list for outcome 1 will fill us up until 9.30. Can I just advise that I do believe the committee should have a hard finish at 9.30 to give sport the hour and a half that they should have. I always worry about who is last.

Mr Bowles: It would be good to get them on earlier.

CHAIR: Indeed. We can certainly aim for earlier. We will now break and we will come back after dinner at 20 past 7.

Proceedings suspended from 18:17 to 19:20

National Health and Medical Research Council

CHAIR: We will recommence with Senator McLucas.

Senator McLUCAS: Do you want to go on to the National Health and Medical Research Council?

Senator MOORE: Okay. I think I am finished with the Cancer Australia people. Is it possible to go to the NHMRC?

CHAIR: Yes, it is.

Senator McLUCAS: Professor, congratulations on your appointment. I hope you will have a long and illustrious career, as your predecessors have had. Given that you are new in the role, could you give us some insight into your vision for the NHMRC? How will the direction go in the future? Do you have any early ideas about changing direction at all?

Prof. Kelso: Thank you very much. It is a great honour to be in this role. I have been involved with NHMRC for many years as a researcher, sat on committees and, in the last three years, also served on council. That has been very fortunate, as it turned out, because it

gave me some insight into the breadth and capacity of the NHMRC. So I think that, to answer your question, we have an extraordinary opportunity at this time in the NHMRC, as we do in the country as a whole, in health and medical research. It is a time of extraordinary advance, and Australia is very well placed because of the quality of its people and the quality of its institutions and infrastructure.

My first concern is that we honour that extraordinary achievement that Australia has built up over many years, partly, of course, through the efforts of the NHMRC, but with the support of the successive Australian governments and the support of the states and territories, many philanthropic bodies and a wide range of supporters. It has been really, I think, a great opportunity for us as a country. So, in coming into the role of CEO of NHMRC, of course I want to see us build on that great strength and see us fund support to the best that we can, despite the straitened times, the full diversity of research in Australia from discovery research, where we can expect that the outcomes, the impact on health, may not be visible for some time, all the way through to more applied research—clinical research, clinical trials, population health research, health services research—where we can see impact in a much shorter time frame.

It is critical for the NHMRC to be able to work across that full spectrum. The support that the NHMRC receives through the Medical Research Endowment Account and other funding, such as the Boosting Dementia Research funding that came in the previous budget, is critical to NHMRC continuing to serve Australia in this way through the support of the very highest quality of research. Critical to that also is that we build our international connections so that we support Australian researchers to work at the highest level internationally with colleagues not only in the fully developed world that we tend to think about—the US and Europe and the UK—but also in the emerging and increasingly scientifically strong economies of Asia, whether it is Singapore, Japan, China or the others which will shortly follow such as India. So our international engagement is critical also to our success as a country in health and medical research.

It is also critical to say that all of our work is ultimately concerned with the health of the Australian people. While, as I said, we fund research across the full spectrum, the ultimate goal of that is to improve the health of the Australian people—whether that is through investigator-initiated research, which is a good deal of what NHMRC funds; or through priority-driven research, which we also fund through, for example, the dementia institute and through our targeted calls for research.

Senator McLUCAS: Thank you very much. I am sure that not only the committee but many others will be keen to hear what you have just said. Have you had any discussions with the minister or the department about their view about the future of the NHMRC?

Prof. Kelso: I have had a number of meetings with officers in the Department of Health to talk about how NHMRC interacts with the department, how we can be an increasing asset to the department in the activities that it has planned over these coming years. I think there is a lot more we could contribute than we have been called upon to do in the past, and we stand ready to do that. I look forward to having that discussion also with the minister.

Senator McLUCAS: So you have not had the opportunity to meet with the minister yet?

Prof. Kelso: I will meet with the minister very shortly.

Senator McLUCAS: When were you appointed, Professor?

Prof. Kelso: I started on 27 April; so that is five and a bit weeks ago.

Senator McLUCAS: In relation to the structure of the NHMRC with its committees and the quite prescribed roles it has presently, are there any plans to change the structure of the organisation?

Prof. Kelso: The committee structure is to some extent determined by the NHMRC Act, so it is not easily changed from that point of view. But with the beginning of the new triennium on 1 July this year we do have a new set of principal committees and, very importantly, we will now have a health translation advisory committee and a health innovation committee. The health innovation committee in particular is a new one for NHMRC and, I think, a very important one at this stage in our history.

Senator McLUCAS: You have noticed with the Medical Research Future Fund that there is a big focus in that fund on innovation. Have you had any discussions with the department about the role of the NHMRC in the disbursement of funds from the Medical Research Future Fund?

Prof. Kelso: We have had informal discussions about that and, in particular, I believe that the NHMRC can offer experience in peer review and all the infrastructure that supports that. We are sitting at the centre of 23,000 researchers in Australia who are engaged in health and medical research, and many of them serve us in many ways through peer review, through sitting on committees, through work on guidelines and a range of policy activities that NHMRC undertakes. I think we are an extraordinary asset, and so I offer that to the department and the government in their plans for the MRFF.

Senator McLUCAS: At this point in time, has the NHMRC received any advice about any additional funding that may be channelled through from the MRFF once the disbursements come and begin to be distributed?

Prof. Kelso: No, we have not had any specific advice yet.

Senator McLUCAS: That is good. It concurs with the secretary's comment from yesterday.

Mr Bowles: Are you checking on me, Senator?

Senator McLUCAS: What is the state of the council at the moment? Are there any vacancies on the council? I should know this.

Prof. Kelso: The current council has its last meeting tomorrow and the next day, and then finishes up at the end of this triennium on 30 June. The appointments for the new council have not yet been announced.

Senator McLUCAS: Minister, when do you expect those appointments to be announced?

Senator Nash: I would have to check with the senior minister's office and I will take that on notice.

Senator McLUCAS: Thank you. Please thank the council members for the work they have done.

Prof. Kelso: I certainly will.

Senator McLUCAS: What is the balance in the medical research endowment account at present?

Prof. Kelso: Do you mean the balance of funds unspent for the year?

Senator McLUCAS: Yes, that is the intent of that question.

Mr Kingdon: The opening balance is $134.1 million. That will then be supplemented through the additional appropriation receipts.

Senator McLUCAS: That came through the last budget?

Mr Kingdon: Through the last budget, yes. But that is the actual balance that was sitting there prior to the appropriation.

Senator McLUCAS: What was the appropriation—just for the record, Mr Kingdon?

Mr Kingdon: The appropriation receipts is $859 million but that is not all. I need to check what goes actually into the MREA—$796.3 million will be going into the MREA.

Senator McLUCAS: Thank you. Thank you very much for attending. Sorry the time has been short but have a lovely evening.

Prof. Kelso: Thank you.

Department of Health

[19:32]

Senator McLUCAS: Will the government release the final report resulting from the review into alcohol advertising and the effectiveness of the current regulatory codes in addressing community concerns which, according to the legislation that governs ANPHA, was due to be released earlier this month?

Dr Southern: I understand it is still under consideration.

Senator McLUCAS: How does the legislation indicate when this report is meant to be released?

Dr Southern: I am not familiar with the legislation unfortunately.

Ms Flynn: I can explain. The ANPHA legislation provides for the CEO to release reports and the CEO resigned on 2 January, so it is a matter for the minister to consider and it is under consideration.

Senator McLUCAS: Right. The parliament has not abolished ANPHA; you are quite aware of that?

Ms Flynn: No. But there is no CEO at the moment.

Senator McLUCAS: Minister, when do we expect this report to be released?

Senator Nash: I do not have anything to add without reconsidering it.

Senator McLUCAS: Minister, when you come along to estimates, they give you briefs.

Senator Nash: Sorry?

Senator McLUCAS: When you come along to estimates, they give you briefs.

Senator Nash: Is that a question?

Senator McLUCAS: No, it is an observation.

Senator Nash: Senator, if the government is considering something—a report, a review, whatever—the government is considering something.

Senator McLUCAS: When do you think it is going to be released?

Senator Nash: Hopefully, it will not be too far away. We could talk about the Henry tax review that, when Senator Wong was minister, took over four months to make any sort of comment on. It happens from time to time that things are under consideration and you well know that.

Senator McLUCAS: You do not have an eloquent answer. What steps are being taken to progress the Australian government's commitment to the World Health Organization's global monitoring framework and targets for the prevention and control of non-communicable diseases? And, in particular, how is the government ensuring that it meets the target of 25 per cent reduction in mortality rates from non-communicable diseases by 2025?

Dr Southern: One of the major pieces of work which is underway at the moment is the development of the National Strategic Framework for Chronic Conditions, which is a piece of work being undertaken under the auspices of AHMAC and the COAG health ministers councils. So the Commonwealth Department of Health is leading that piece of work and the development of the framework, in consultation with the states and territories. We have a workshop roundtable discussion with the stakeholders next week where we will be looking at the scoping paper for that. There are particular references in this scoping paper to commitments under those WHO guidelines and targets. Certainly the intent of the framework is to develop an approach where we will be able to look towards achieving those targets.

Senator McLUCAS: That is a framework that is being developed at the moment. Is that what you are telling me?

Dr Southern: That is correct. It replaces a framework which has been in place since 2005 and, yes, the work has commenced to develop a new framework going forward.

Senator McLUCAS: Who will take responsibility for developing that objective in the light of the closure of ANPHA, which was established to drive this sort of policy development and not only the policy development but the response to the policy development, into the community conversation?

Dr Southern: The functions of ANPHA have transferred to the department and, as I said, we will be leading the work in consultation with the states and territories on developing the national strategic framework. So that will be a piece of work that we are taking forward.

Senator McLUCAS: Is there are time frame for completion of that work?

Dr Southern: The intention is that we have that framework in place—it will probably go to AHMAC and ministers towards the end of next year.

Senator McLUCAS: Is that in line with our responsibilities to the WHO?

Dr Southern: Yes, I believe so.

Mr Bowles: Yes, it is.

Senator McLUCAS: What is the sort of next drop-dead event that we have to do with WHO?

Ms Flynn: There is reporting on our progress against achieving the targets for the first time in 2015, so at the end of this year we will deliver a report.

Senator McLUCAS: That is a progress report?

Ms Flynn: That is right.

Senator McLUCAS: Just going to alcohol and other drug sector funding, we have done a comparison of funding—funds from the drug strategy budget that compare the 2013-14 papers, the 2014-15 papers and the 2015-16 papers, which shows a really large decrease of funding. For example, in 2014-15 the change from the 2013-14 budget papers is $81 million, which grows this budget to $103 million and in 2016-17 to $124 million. Can the department or the government explain why it is continuing to cut funds at this very high rate from the drug strategy budget?

Dr Southern: Part of that reduction is a transfer of funds to the Department of the Prime Minister and Cabinet with machinery-of-government change.

Senator McLUCAS: Can you help me in identifying what proportion of those cuts are transfers and can you confirm they are continuing to fund drug strategy programs.

Dr Southern: The functions that were transferred to the department of Prime Minister and Cabinet were three of the priority areas that were covered by the Substance Misuse Service Delivery Grants Fund. The three priorities were assisting Indigenous communities to provide service delivery; supporting those services targeting Aboriginal and Torres Strait Islander people; and reducing prevalence and impact of petrol sniffing. The funds being transferred to PM&C would now be part of the Indigenous Advancement Strategy funding overall.

Senator McLUCAS: You cannot confirm that they will be still applied to drug strategy in the broad. That is just the nature of what has happened to those funds. But I am trying to understand now, Dr Southern, the quantum that was transferred.

Dr Southern: We will take on notice for you the exact amounts, but I understand it is around $90 million in 2014-15 to support Indigenous communities and services to provide drug and alcohol treatment, and the petrol-sniffing priority as well.

Senator McLUCAS: And that is compared to the 2013-14 budget?

Dr Southern: I will take that on notice. I do not have the comparison between the years that you were quoting earlier. I know that a substantial amount of money was transferred as part of the machinery government changes.

Senator McLUCAS: What I am trying to identify then, if certain moneys have been transferred to PM&C, what will be left in the drug strategy budget once those monies have been transferred?

Dr Southern: Senator, for 2014-15 and 2015-16, it is in the order of $87 million for drug and alcohol treatment services.

Senator McLUCAS: I am using a nomenclature of drug strategy budget; you are talking about AOD services through the flexible fund?

Dr Southern: It is funding that is through the flexible fund, the Substance Misuse and Service Delivery Grants Fund, but also from the Non-Government Organisation Treatments Grands Program, which is not a flexible fund. That is part of the overall funding for the drug strategy.

Senator McLUCAS: If you can provide us those moneys were transferred under a banner called Drug Strategy Budget so we are talking about the same thing, that would be helpful.

Dr Southern: These two programs are components of the drug strategy.

Senator McLUCAS: Thank you. Now that the government has defunded the Alcohol and other Drugs Council and closed the Australian National Council on Drugs, what is the strategy for receiving advice from people who represent people in the alcohol and other drugs sector at the national level? What are the consultation mechanisms that are adopted by the department?

Dr Southern: The Australian government has established ANACAD, which is the Australian National Advisory Council on Alcohol and Drugs, and it provides efficient advice direct to the Australian government on high-priority alcohol and other drug issues.

Senator McLUCAS: Is that an independent body?

Dr Southern: Yes, it is.

Senator McLUCAS: But it is supported by the department?

Dr Southern: Yes, in the way that we support other advisory councils.

Senator McLUCAS: But the secretariat to it is in the department.

Dr Southern: Yes.

Senator McLUCAS: I do not know how you can say that is an independent body, if the secretariat to the organisation is in the thing that it is advising.

Senator Nash: I think it is quite easy to say that. The council has been set up to give independent advice, and the department provides secretariat services to the running of the committee. I would not like to think that anybody was casting any aspersions on the department to be able to provide a secretariat role while not interfering with the independent advice of the body they are providing those secretariat services to.

Senator McLUCAS: So who is providing briefs to go to the national advisory council?

Dr Southern: The secretariat.

Senator McLUCAS: They sit in the same building as everyone else in the department, don't they?

Ms Flynn: Yes.

Senator McLUCAS: How is that advice independent?

Senator Nash: Let me make this very clear. I will say this very simply so that everyone can follow.

Senator McLUCAS: Do not treat me like that.

Senator Nash: I am saying that to everyone listening. The secretariat sits within the department. The number of people is very small. There are four people in the department providing secretariat advice to the Australian National Advisory Council on Alcohol and Drugs. It is a structural committee that provides them secretariat support. It does not provide advice to government. The advice to government comes directly from the council.

Senator McLUCAS: Minister, we had organisations for 30 years or 40 years—I cannot recall which—that provided independent advice to governments, advice that sometimes was

not palatable, from the alcohol and other drug sector. Sometimes governments of whatever flavour did not want to hear that advice. We have been able to have a pretty progressive evidence based drug and alcohol policy in our nation because of that. This is a fundamental shift in the independence of advice to government around a highly contested space. What are you going to do when your department provides not necessarily advice but data to an advisory council that advises against a policy that your government wishes to pursue? That is a conflict, and it is a conflict that has been generated by the structure that your government has established.

Senator Nash: I do not believe it is a conflict. I hope you are not insinuating that the council is not able to provide me independent advice because it has secretariat support from the Department of Health. Each and every one of the positions on that council is filled by a highly reputable person—

Senator McLUCAS: I have never—

Senator Nash: Let me finish.

Senator McLUCAS: made any reflections on those individuals.

Senator Nash: You are. Let me finish. They are highly reputable and experienced persons in a variety of fields who were chosen for their independence and ability to provide advice to government on that basis. I have absolutely no reason to believe that the advice that will come to me from that council will be anything but independent. If you have a different view, that is your view; it is not mine.

Senator McLUCAS: You do not see any conflict at all in having a secretariat to your advisory committee in your own department?

Senator Nash: They are providing secretariat support. The advice comes from the council and, no, I do not.

Senator McLUCAS: Who directs the workflow program for the advisory group?

Dr Southern: The council.

Senator McLUCAS: Where is the Chinese Wall between requests from the council to your department that allows for those requests to be fulfilled without compromising the work of the department?

Mr Bowles: This is not a unique situation. I would respectfully say that the department can provide a range of secretariat type of supports for any independent group that provides advice to ministers. It happens across all types of organisations. We do not influence outcomes. That is not the job of secretariats to independent councils. Independent councils are smart enough and usually educated enough in their topics to not be influenced by anything that the department might do or say.

Senator McLUCAS: I am talking about back the other way now, Mr Bowles. When the council asks the secretariat for a set of data or some analysis, where is the Chinese Wall—I do not like that term, but it works—between the operations of your department and the request for advice, information or data from members of your department to an advisory—

Mr Bowles: The secretariat will request it from parts of the department. That is what happens all the time.

Senator McLUCAS: Alcohol and other drugs is a really contested space. There is a lot of—

Mr Bowles: There are a lot of contested parts of the health portfolio.

Senator McLUCAS: I understand that, but this is a big one where there are very strongly held views.

Mr Bowles: I think it is unfair, though, to suggest that we might be influencing independent advice to the minister because they happen to sit in the department.

Senator McLUCAS: I am not saying you—

Mr Bowles: I think that is a little bit of a stretch.

Senator McLUCAS: I take that. I am not saying the department was influencing independent advice to the minister, but—

Senator Nash: I thought that was exactly what you were saying.

Senator McLUCAS: the structure puts the advice mechanism in the same structure that provides potentially alternative advice.

Mr Bowles: That happens in a range of different functions, and it has happened in other departments where I have worked. I would suggest that the professionalism of the Public Service is such that we can manage these sorts of issues. We do it all the time.

Senator McLUCAS: I put it to you that it is probably not the most desirable mechanism to provide—

Mr Bowles: If someone were to come to me and tell me that there was a problem and there was some undue influence one way or the other, I would immediately investigate what was happening there. That has not been the case.

Senator McLUCAS: It has only been there for a little while.

Mr Bowles: That is right, but it still has not been the case. It has not been the case in any of the other independent bodies that we support, and there are few of those as well.

Senator McLUCAS: Sometimes you have to structure things to mitigate against criticism and, this time, it has not happened that way. I am not saying that is your mistake, Secretary; I am saying it is a government mistake.

Senator Nash: I think there was a Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections that had the same secretariat support. It gave what was considered independent advice. It ran under Labor. There were no complaints about it then. So, as a structure, this is not without precedent. Again, I take great umbrage at any suggestion that officials in the department cannot provide advice to a council of an independent nature for that council to provide independent advice to government.

Senator SMITH: There has never been any skerrick of doubt that the ministerial advisory committee referred to by the minister has provided anything but independent advice.

Senator McLUCAS: But with the ministerial council on blood-borne diseases we also do not have a very large alcohol industry sitting out to one side with a different agenda. That is the big difference.

Mr Bowles: Does that mean the department is influenced by the alcohol industry?

Senator McLUCAS: Absolutely not.

Senator Nash: That is the implication you are making.

Senator McLUCAS: We have already had trouble with some healthy food labelling in this government's history, so let's be very careful.

CHAIR: You are stretching it a bit here, Senator McLucas.

Senator SMITH: There is no conspiracy here; I think we should move on.

Senator McLUCAS: Okay. I am happy to.

Senator MOORE: I wanted to ask some questions about the TV advertising campaign that has just been run. Did the department conduct research on the effectiveness of TV advertisements as a tool for diverting young people from drug use?

Dr Southern: The short answer is yes, but we will get our colleague Mr Davey to expand.

Senator MOORE: It is about the whole process, Mr Davey, about the research that was done before the advertisement was put in place—about the effectiveness of TV advertising.

Mr Davey: We did conduct research to inform development of the campaign and we have of course conducted evaluation research on earlier campaigns we have run on ice and other drugs. The research we conducted earlier this year specifically to inform the development of the current campaign did show us that the advertising being proposed—which is now being used—was seen as highly credible and likely to be effective in reaching the target audiences. For this campaign, that includes young people, parents of young people—about age 14 to 17—and young adults who are at high risk of being exposed to drug use, particularly ice. The research showed clearly that the proposed advertising material was highly likely to be effective. That is consistent with previous campaigns we have run.

Senator MOORE: Who conducted the research, Mr Davey?

Mr Davey: The company that conducted that research was called Snapcracker Research and Strategy.

Senator MOORE: Are they on a panel?

Mr Davey: Yes.

Senator MOORE: Had they done work for the department before in this area?

Mr Davey: Yes, they have done some research for us in this area previously. They did some research in 2013.

Senator MOORE: In what area?

Mr Davey: In relation to drugs campaigns—developmental research, formative research.

Senator MOORE: There is body of research, then?

Mr Davey: Yes, the evidence base is very strong.

Senator MOORE: Over a period of time?

Mr Davey: Yes, as you would expect.

Ms Flynn: Senator, if you were asking specifically about TV viewing, the way young children view TV these days is different. The campaign that is running at the moment takes that into account. There is more online content.

Senator MOORE: It is a combination package.

Ms Flynn: Yes.

Senator MOORE: Did the department recommend that the government conduct a national television advertising campaign? Was that a recommendation from the department?

Mr Bowles: These are government decisions.

Senator MOORE: I am interested in the process. I would like to know the sequence of the idea, the campaign and the action.

Mr Bowles: Ideas can come from multiple places. Often they are policy decisions of government.

Senator MOORE: Was it a government decision or was it based on departmental research?

Mr Bowles: I will answer your first question. Ideas can come from a lot of different places. Governments set policy—and this is a policy issue. But there is a process for the development of campaigns. It goes through a formal structure to get approval. That is the process Mr Davey can talk about for this particular campaign.

Senator MOORE: The advertising campaign was a policy issue?

Mr Bowles: The campaign itself is not a policy issue, but the issue is a policy issue. As far as the campaign goes, it goes through the campaign approval process.

Senator MOORE: My original question was about whether the decision to go with a TV advertising campaign was recommended by the department or whether, as you seem to be saying, it was a decision of government. It is not the decision about whether something needs to be done about the drug issue—which I see as the policy decision—it is the decision to make it into a TV advertising campaign.

Mr Bowles: Again, that is a decision of government.

Senator MOORE: It is an action of government.

Mr Bowles: Governments decide.

Senator MOORE: I am not going to get anything out of that. With regard to the process, Mr Davey, the government made a decision that something had to be done about ice. What was the formal process, then, that led to the selection of this type of campaign—and is the research from Snapcracker public? Are the assessment and recommendations from Snapcracker about what they thought was a good way to go publicly available?

Mr Davey: That research is developmental research. We have certainly made the research available.

Senator MOORE: Yes, you have.

Mr Davey: I refer to a recent media article talking about secret research and I would like to put on the record that we released that research last year to a journalist because they asked for it. We have also released it to other tenderers for processes in relation to the campaign. There is no secret research—just to put that on record—as was reported.

Senator MOORE: I am not sure where the secret came from.

Mr Davey: It was a media article that referred to this research—

Senator MOORE: It was not from me.

Mr Davey: No.

Senator MOORE: I would like to see the research.

Mr Davey: We do make research available. All the evaluation reports have been published on our campaign website.

Senator MOORE: Yes, I have seen that, but not the research. I have seen the evaluation but I would like to see the research.

Mr Davey: We can make that research available.

Senator MOORE: That would be great, thanks. So we went down that process—

Mr Davey: We have complied with the guidelines on information in advertising on Commonwealth entities. To take you through that process, it is the same process that we take all of our campaigns through—

Senator MOORE: By the guidelines.

Mr Davey: Yes; complying with the guidelines, of course. The campaign is informed by evidence so we use the available evidence in relation to a particular issue—in this case drug use in Australia. We also use the evaluation research from previous drug campaigns that we have run. We commission formative research to explore concepts—that is, how you best communicate this with the intended target audience, which we have done. Then we test proposed materials to determine their effectiveness and to refine them. That is where some of the selection comes in in relation to do you run a TV ad; do you run a YouTube campaign; or do you run Facebook, social media, print radio or whatever. That is generally informed by the research and also by the media agency who buys the media and makes those recommendations.

Senator MOORE: Over what period of time was that done in this process, Mr Davey?

Mr Davey: As I said, we did undertake research as far back as 2013. That research I can make available. That was undertaken by Snapcracker research + strategy, which we use to help develop concepts and to test different ways that you might communicate. As you would appreciate with these types of campaigns on complex issues, it is an intuitive process that takes some time to get there, so we undertook some research in March this year as well. Snapcracker—

Senator MOORE: So in 2013 there was research and that was done around a previous campaign?

Mr Davey: No, that was qualitative research to explore concepts for this next stage of the campaign.

Senator MOORE: So there was already consideration of this program around the ice strategy as far back as 2013?

Mr Davey: No only ice for this campaign but also we will consider a range of different drugs.

Senator MOORE: So there is the research from 2013, which we will get and it was from Snapcraker, and, then, the last time was when?

Mr Davey: In March this year.

Senator MOORE: In March 2015?

Mr Davey: Yes.

Senator MOORE: So there was nothing between 2013 and 2015?

Mr Davey: Not in terms of formal research.

Senator MOORE: There was more research done then?

Mr Davey: Yes; to explore the advertising concepts; to test them, to make sure they are going to be effective, for seeking recommendations and for refining them. We did two rounds of concept testing.

Senator MOORE: That was in that March to April period?

Mr Davey: Yes.

Senator MOORE: When did the actual campaign start?

Mr Davey: The campaign started on 10 May this year. It includes television, cinema, online and social media, and that runs through until the end of this month at the end of June.

Senator MOORE: The end of June?

Mr Davey: Yes.

Senator MOORE: That is similar to the previous one that we talked about in terms of timing, isn't it?

Mr Davey: I think so.

Senator MOORE: So that is May-June. Can we get the costs of all of that?

Mr Davey: You can. We obviously have not expended all of the budget just yet so I cannot give you an exact media buy. You may appreciate that it depends on which media spots they actually achieved et cetera so the final amount may vary. The total campaign budget is up to $11 million for this phase, and that includes everything so research—

Senator MOORE: Does that include all the way back to the 2013 research, or does it kick in from the March 2015 research?

Mr Davey: I think that is for this financial year.

Senator MOORE: So that would be around this campaign—

Mr Davey: This phase of the campaign; that is right.

Senator MOORE: The first expenditure would have been the March 2015 research from Snapcracker.

Mr Davey: Yes.

Senator MOORE: And the budget goes up to $11 million so you will be receiving invoices as you go and you will not be able to conclude that until—

Mr Davey: That is right. We will probably not spend that entire amount. The indicative value of the media buy is around $7 million of that. It includes three different TV ads in that mix.

Senator MOORE: That is across the country—the national campaign?

Mr Davey: Correct. That is right.

Senator MOORE: There would be different buyers in all the different regions and so on.

Mr Davey: Yes, with a focus on regional as well to get maximum coverage across the country.

Senator MOORE: For this area, what is the evaluation mechanism?

Mr Davey: We will be using a research company to evaluate the campaign. That evaluation research will commence this month. The research company has not been appointed yet, which is why I do not have their name. We will go through a select tender process in line with the guidelines. That is underway at the moment. We will evaluate it. It will not be the same company that informed the development of the campaign, which is standard practice.

Senator MOORE: Is that part of the $11 million?

Mr Davey: Yes, absolutely.

Senator MOORE: Would you anticipate that most of that would be done in this financial year?

Mr Davey: No, not necessarily. The campaign is running until 30 June, so I would actually expect that it will go into—

Senator MOORE: So there will be expenditure in the 2015-16 year?

Mr Davey: I think necessarily there will have to be.

Senator MOORE: When was the last major multimedia campaign around drugs?

Mr Davey: 2009-10 was the last time we ran a drugs campaign.

Senator MOORE: So did the 2013 research that was looking at concepts and processes in this area take into account the evaluation of the 2009-10 program?

Mr Davey: Certainly we did consider evaluations of previous campaigns and the new research in informing activity. The research company is doing new research this year.

Senator MOORE: Was the 2009-10 campaign a multimedia strategy as well?

Mr Davey: It certainly was. There was only one TVC and one banner ad. Back in 2007 when we made that last series of advertising we did not have the same range of online media options and viewing applications. So it was a much more limited series of executions than we have this time.

Senator MOORE: You may not have the data with you, but can we get information on how much that 2009-10 campaign cost to make a comparison.

Mr Davey: I might have to you take that on notice.

Senator MOORE: That is fine. You can take that on notice. It is just about building up the body of evidence and information on cost and then looking at value for dollar.

Mr Davey: Yes, absolutely. I can tell you that it cost around $700,000 just to develop the 2007 TVC and materials.

Senator MOORE: There may not be a direct comparison, but it just sounds to me as if there could well be for some of the processes that have been put into place. This is an $11 million program. All of this development was done by external agencies?

Mr Davey: That is right.

Senator MOORE: Just through the normal tender process?

Mr Davey: Yes.

Senator MOORE: We have talked a bit today about the flexible funds and the various programs that look into the area of drugs and alcohol. Senator McLucas was asking some questions around The Substance Misuse Service Delivery Grants Fund. Is there also one called the Substance Misuse Prevention and Service Improvement Grants Fund?

Dr Southern: Yes.

Senator MOORE: So there are two flexible funds?

Dr Southern: Yes.

Senator MOORE: In questions earlier we were asking what was in what flexible fund. We are still getting to the bottom of that. Mr Bowles told us that consideration is being undertaken now looking at how the overall reduction in flexible funds would operate. There is no direct knowledge about what, if any, expenditure in those two funds would be undertaken?

Mr Bowles: That is correct.

Senator MOORE: So I then have a general question. Minister, you may need to respond to this rather than putting the officers in the position to do so. At the same time as we are spending $11 million on a specialised campaign, there are concerns in the community about potential, not confirmed, losses to front-line services that are now being funded. In terms of that dichotomy, what is the priority and what is the response from the government to assure people that there is an overall strategy when you are giving with one hand and taking away with another?

Senator Nash: I would have to disagree with that last comment you made, because I think we and the department have been very clear that, on the flexible funds, there has been no decision made yet. I want to be very clear that there have been no decisions made around any of those funds, including the programs you are talking about. So I think saying that we are giving with one hand and taking away with another is completely incorrect, because we do not know yet how the arrangements will work with any changes to flexible funds.

In terms of the development going forward with the drug strategy itself around ice, you would probably be as aware as anybody that with this particular drug the rapid escalation we have seen over the last couple of years has been exponential. I have been around half the country and I am about to do the other half at the end of this week conducting consultations. As you would know, the task force is in place and separately doing its consultations around the country. I do not think there can be any misunderstanding about how committed the government is to an effective strategy to try to tackle this drug. The task force will report the interim report back to the Prime Minister in the middle of July. There will be a final report before September. The Prime Minister will then take that to states and territories through the COAG process, with a view to forming a national strategy. That sits separately to any discussion around flexible funds when we are yet to make any decisions around any of those changes to flexible funds.

Senator MOORE: Is the only funding for front-line drug and alcohol services from the Commonwealth through the flexible funds?

Senator Nash: That I will need advice on. I do not think so, no. We just had the $87 million commitment for the next 12 months to front-line services. So there is certainty there for 12 months. But I will hand over to the department to answer further.

Dr Southern: The $87 million for services which the minister just mentioned comes from one of the flexible funds, the Substance Misuse and Service Delivery Grants Fund.

Senator MOORE: I did not want to say, but I knew that. That is definitely from the flexible fund.

Dr Southern: Yes, that is definitely from the flexible fund. Then about half of the funding is from the Non Government Organisation Treatment Grants Program, which is not a flexible fund.

Senator MOORE: Which is the one you were just talking about?

Dr Southern: That is right. It is not a flexible fund.

Senator MOORE: How much is from that one? The $87 million is definitely from one of those ones that sound very similar.

Dr Southern: The $87 million is jointly provided. There is about $45 million from the flexible fund and about $42 million from the Non Government Organisation Treatment Grants Program.

Senator MOORE: And that is a different grants process?

Dr Southern: No, they are the same grants process but from two separate sources.

Senator MOORE: So they are actually tendered at the same time but are two different streams of funding?

Dr Southern: That is correct, although this time the funding has been offered to existing service providers in the 12-month extension.

Senator MOORE: You would know, Minister, having spoken to many of the organisations as you have been going around—and I am sure the department has as well—that there is a concern about future funding for some of the organisations that have been working in the field for a long time. There is also a specific concern at this stage on the basis that, if these ads do their job, they are going to raise awareness and people will be seeking further support. I would imagine that would be one of the evaluation models—that is: what is the response to the campaign? When you are creating a demand and people are going to be working on the front-line, they need to feel fairly confident about their own work security and also about future planning.

The other thing I am aware of is the focus on an innovative response to the problem. If you have an awareness-raising campaign, which is the ad one, you are looking at the organisations who are providing the response coming up with novel ways to respond. The idea is that you need to have security if you are going to be innovative.

Senator Nash: It is a very important point that you raise. The reason why I wanted to make a comment here is that one of the things the task force is actually looking at as part of the process is rehabilitation and treatment services and where things are working well, where they are not and where there are gaps. I think there was a view in some quarters to start with that the government strategy would be about law enforcement, and certainly that is a part of it—I have to say that our police do an amazing job, as do those who work protecting our borders. The work that the task force is doing is much broader than that. It is looking right across a whole range of areas including demand, education and what we need to be doing

there, and includes the issues that you have just raised. I just want to make sure that it was very clear that that is actually part of the process.

Mr Davey: I wanted to make the point that it is not a cessation campaign like the 'quit smoking' campaigns. We are mindful of providing information for people in terms of support and that includes also information for parents in terms of how to have conversations—

Senator MOORE: And that is why they will contact the organisations, Mr Davey. I have seen some of the ads and they are telling people that if they are worried or if they are concerned then they should contact.

Mr Davey: We are mindful that we are not driving contact—that is not the main purpose. That is the point I wanted to make.

Senator McLUCAS: What is the drive then?

Mr Davey: To raise awareness of the harms of ice amongst high-risk young people, to encourage parents to talk with their children and to increase the likelihood of young people avoiding the drug—they are the main aims. We are, of course, mindful of the need to point people to support but we are not trying to push people in the same way that we would with the 'quit smoking' campaign where we advertise the Quitline. They are slightly different models.

Senator MOORE: When we get the costings can we also get the indications of what percentage of the funding is going to which component. Certainly there is research and evaluation, but I am also interested to see what the balance is with the spend for the TV component and the social media component.

Food Standards Australia New Zealand

[20:18]

Senator McLUCAS: Can you please give me an update on actions that have been happening in FSANZ since last estimates when we talked about berries and hepatitis A.

Mr McCutcheon: The major development since my last appearance at this committee on 25 February has been the completion by FSANZ of the risk assessment on imported frozen ready-to-eat berries. That assessment was completed on 7 April and basically came to the conclusion that imported frozen ready-to-eat berries were of low risk provided they were produced with good agriculture practice and processed with good hygienic practice. That advice has been provided to the Department of Agriculture, and on 19 May, I think it was, they announced the new requirements that would apply to importers on the basis of our risk assessment advice.

Senator McLUCAS: Thank you. In the department, what has occurred in the same period of time?

Prof. Baggoley: As at late last week, 29 May, there have been 33 notified cases of hepatitis A virus infection, 14 from Queensland, 11 from New South Wales, four from Victoria, two from WA and one each from South Australia and the ACT. They had all consumed Nanna's frozen mixed berries. Twenty-eight of the 33 cases were found to be genetically identical, indicating a common source. All these had hepatitis A and all had eaten Nanna's berries. Of the five that were not genetically identical, one had a different sequence and it was felt almost certainly that they had obtained their infection overseas. Two had different sequences, and different from each other, but had not travelled, therefore thought to

be locally acquired from other sources. Two were unable to be genotyped as they were diagnosed on serology only. That brings it up to the 33.

Testing of food is said to be an unreliable way to detect the virus, because it is not so easy to find, but testing confirmed evidence of the hepatitis A virus at trace levels from a sealed packet of the product and the outbreak strain was also confirmed in an open packet retained from a case. The only other thing to report is that, on 24 March, given the number of cases had certainly levelled off, you will recall there was discussion at last estimates about the activation of the National Incident Room; I deactivated it at that stage, and there have been no further cases since.

Senator McLUCAS: That was at 24 March?

Prof. Baggoley: Yes, and we were well beyond the incubation period then. OzFoodNet and CDNA stood down the active multijurisdictional outbreak investigation on 27 May, just last week, which was 100 days after the voluntary recalls, making further berry associated cases highly unlikely. So the outbreak is over. I think the investigation, from start to finish, has been thorough, and the evidence speaks pretty clearly.

Senator McLUCAS: Thank you. I understand the government has moved to strengthen the country-of-origin labelling regulations, which, in and of itself, is a reasonable thing to do. I want to know how country-of-origin labelling could have helped to avoid the outbreak of hepatitis A.

Dr Southern: Senator, you are right—there is some work underway at the moment in relation to country-of-origin labelling. That goes to the ability of the public to have clear information about where food products come from. In relation to the hepatitis A outbreak and the berries, my understanding is that those packets were labelled with the origin of the berries—I cannot remember the details of it now, but there was certainly some information there. There is also feedback from consumers that they find the current country-of-origin labelling confusing.

Senator McLUCAS: Yes. It has not changed for a very long time. It has been that way for a while. In terms of inspection, that is not the responsibility of Health in any way at all. Mr McCutcheon, you have advised Agriculture of your assessment of low risk.

Mr McCutcheon: Yes.

Senator McLUCAS: But you did indicate, I think, in your earlier evidence that there was going to be increased surveillance? You cannot speak for the Department of Agriculture, but—

Mr McCutcheon: No, I cannot, but I can certainly refer back to the evidence I gave at the last hearing of this committee about the case of the berries that were implicated in the particular issue we are dealing with. Following the receipt of advice from us, the Department of Agriculture were able to move those berries—from two factories in China—into the risk category where 100 per cent testing was required. My understanding is that that risk categorisation remains in place. Further on from that advice, the Department of Agriculture implemented further testing at the border under the surveillance program for all imported berries—that is the five per cent testing. I should clarify: that was for E. coli testing—process hygiene indicators. The product from the two factories in China was tested for both E. coli and hep A testing.

Senator McLUCAS: From a food safety point of view, will additional testing assist in improving food safety in cases like that—where we have contaminated product being imported into the country?

Mr McCutcheon: It depends on what you are testing for. In the case of viruses in food, routine testing is problematic—because the technology is not sufficiently advanced to give definitive findings. As per the evidence I gave at the last hearing, testing for viruses in food is more useful when you discover you have a problem. It can then assist in helping to identify where that problem has emerged from. You can also check at various points of the production chain to identify where there may have been a breakdown. It is not a very effective test at all in the sense of end point testing.

Senator McLUCAS: What about the efficacy of additional production site inspections? Has that been shown to be more effective?

Mr McCutcheon: They are probably questions better answered by the Department of Agriculture.

Senator McLUCAS: Thank you for the update.

Senator SIEWERT: I want to go back to Professor Baggoley's point that the testing of the food confirmed the presence in the packets—unopened and opened. Do I understand that correctly?

Prof. Baggoley: Yes. There was evidence of the hepatitis A virus at trace levels from a sealed packet of the product. The outbreak strain was also confirmed in an open packet retained from a case.

Senator SIEWERT: That was testing that was done by you?

Prof. Baggoley: Not by the department but by the appropriate—

Senator SIEWERT: We are referring to the testing of the samples that the company did?

Prof. Baggoley: No, we are referring to testing that was conducted by the laboratories engaged by the Victorian department of health—independent of the packaged food companies.

Senator SIEWERT: I should have been clearer in my question. I meant 'not by the company'.

Prof. Baggoley: That is correct, yes.

Senator SIEWERT: There were reports that the company had done testing and did not find any indication of infection, whereas the Victorian testing did.

Prof. Baggoley: Correct.

Senator SIEWERT: Is that enough to convince you that the Nanna's frozen berries were the source of the contamination?

Prof. Baggoley: I was well convinced beforehand—due, first of all, to the epidemiological evidence of the hepatitis infections coming from people who had consumed the berries. In particular, though, it was that in 28 out of the 33 cases the virus was genetically identical, indicating a common source. For me the testing was just a piece of confirmation. In my mind, the case was made particularly with those genetically identical virus cases.

Senator SIEWERT: In terms of the Nanna's packets that were returned and taken off the shelves, have you had any discussions, or has the department had any discussions, with the company about the disposal of that stock? I did ask the department this time last week. They were still working out that process, as I recall.

Prof. Baggoley: That has not been put to me.

Mr McCutcheon: FSANZ has not.

Mr Bowles: That may be an issue that is best asked of Agriculture.

Senator SIEWERT: The department just deals with that. They do not hold discussions with—

Prof. Baggoley: Not necessarily.

Mr Bowles: That is an Agriculture issue as far as testing and the like and talking with the companies. We do not have anything to do with that. We follow the illness issue through.

Senator SIEWERT: So you would assume that any of the berries that came from those two processing facilities—and there were a couple that went elsewhere—were also potentially contaminated?

Prof. Baggoley: I think I can just present the evidence as we have it. As to where they have come from and so on, I am not quite sure. As Mr Bowles has said, we follow the illness.

Senator SIEWERT: I understand that FSANZ has undertaken a process to change the maximum residue levels for a number of chemicals used in or on food. I understand that the changes to MRLs were requested by the Australian Food and Grocery Council, BASF Agricultural Solutions, Bayer CropScience—a whole range of food-related organisations. Is that correct?

Mr McCutcheon: There is a process that FSANZ runs generally every year where we prepare a proposal under our legislation and make amendments to standard 1.4.2, the MRL standard, to fill any gaps that might have arisen that are becoming trade restrictive—for example, for chemicals that might be used overseas but are not registered for use here and so there is no MRL in the food standards code, companies have the opportunity to seek an MRL for that. Of course, they can apply themselves through an application process. We run those proposals once a year and invite a whole range of organisations to put in submissions if they wish.

Senator SIEWERT: The example you just used was for chemicals that you do not have one for. Did I understand what you said correctly?

Mr McCutcheon: That would be for chemical-commodity combinations where they are not in the food standards code. There is no MRL.

Senator SIEWERT: I understand that issue. My question is about changing an existing MRL.

Mr McCutcheon: Yes. That has to go through the FSANZ statutory process.

Senator SIEWERT: I appreciate you telling me the additional information. The companies I articulated and the question I asked was about increasing or changing some current MRL levels. That is correct, is it not?

Dr Healy: I probably cannot respond to the precise examples that you are giving. We would have to take that on notice and check what applications and information requests we have had. In the process that Mr McCutcheon has outlined, sometimes there are differences in the use of chemicals between countries, and sometimes we will be asked to make an amendment within the food standards code to take account of a different nature of use in another country. Sometimes there can be changes that result from that process as well.

Senator SIEWERT: In the one that you did in February, which I understand is M1010?

Dr Healy: Yes.

Senator SIEWERT: Did the companies initiate that or did FSANZ initiate it?

Dr Healy: That is the annual process that Mr McCutcheon referred to, where we provide an opportunity for companies, countries, industry associations to provide requests for changes to enable imported foods where the use of the chemical may be different in another country.

Senator SIEWERT: I understand that at least some of the MRLs that were proposed for changing then in fact exceed the MRLs of the codex. Is that correct?

Dr Healy: Again, I would need to check the detail. In looking at those requests, what we always do is ensure that public health and safety is not compromised. The way we do that is by looking at the request that has been made to us and, using Australian food consumption information, determine how much of that chemical may be consumed. Then we would compare that level of consumption to what is called a health-based guidance value—so that is really a safety level—and ensure that there are no exceedances of that health-based guidance value, and we do not approve any chemicals where there are exceedances.

Senator SIEWERT: You do not approve any chemicals where there is exceedance of—

Dr Healy: Of the health-based guidance value.

Senator SIEWERT: Which is different to the codex?

Dr Healy: That is right.

Senator SIEWERT: So, why don't you use the codex?

Dr Healy: The codex is actually the MRL; it is not the safety level.

Senator SIEWERT: Okay. How is the MRL of the codex set?

Dr Healy: It is set on a global basis, so it is going to take into account consumption patterns from around the world. We are looking at Australian consumption patterns. So there will be, obviously, differences in the Australian consumption pattern from what you would see if you looked at a global pattern.

Senator SIEWERT: You are looking at Australian consumption patterns but you are harmonising that to our trading countries.

Dr Healy: We are trying to, where it is possible, facilitate trade while ensuring that the product or food remains safe within the Australian food supply.

Senator SIEWERT: I have a series of questions around that. When you talk about the health-based guidance, how does that then relate to the dietary exposure assessment?

Dr Healy: The dietary exposure assessment is the part of the process where we look at the food consumption patterns within Australia and the products in which the chemical may be found and do an estimate. We have a proprietary computer-based modelling system that

enables us to determine how much of the chemical may be ingested. That is the dietary exposure element.

Senator SIEWERT: That is part of the health-based guidance?

Dr Healy: No, the health-based guidance value is a safety level that is set through an expert process. Then we would compare our estimated intake from our dietary exposure assessment with the safety level, which is the health-based guidance value.

Senator SIEWERT: But you do a health-based guidance safety level for Australian circumstances based on the Australian consumption patterns?

Dr Healy: There are two processes. One is the exposure or the intake side. That is based on our local circumstances. Then there is what is called the health-based guidance value—you might know it as the ADI. That is set by looking at toxicological information that tells you at what level does a particular chemical cause a safety concern.

Senator SIEWERT: For each of the MRLs that were proposed to be raised, was a DEA undertaken for each of those?

Dr Healy: Yes.

Senator SIEWERT: Thank you. So you use the best available science for each of the MRLs and for each time you undertake this process.

Dr Healy: Yes, correct.

Senator SIEWERT: For each of the MRLs that were in the report, that is the process that was used.

Dr Healy: Yes. Within the report there is a summary. At the back of the report there is a summary of those exposure intake estimates.

Senator SIEWERT: Do you look at particularly susceptible populations? You know what I mean.

Dr Healy: When the health-based guidance values, the ADIs, are set, it takes into account any variation in population groups.

Senator SIEWERT: So you would use the most susceptible populations as the base?

Dr Healy: Yes. There is usually a single health-based guidance value, but that is set taking into account any significant susceptibilities—if there was a difference between children and adults, for example. It is usually a single value, but it takes into account any differences in susceptibility.

Senator SIEWERT: Does it include cumulative impacts of those chemicals, where that is appropriate?

Dr Healy: Generally it is a case-by-case assessment, rather than a cumulative assessment, largely because the methodologies for doing cumulative assessments are not well defined.

Senator SIEWERT: So you do not do cumulative assessments?

Dr Healy: That is right.

Senator SIEWERT: Does the data that you use include independently peer reviewed studies?

Dr Healy: Yes. The health-based guidance values that we use for this particular process are either set through the Office of Chemical Safety within the Department of Health, or through an expert body that is jointly convened by the World Health Organisation and the Food and Agricultural Organisation. Both of those groups are reviewing the relevant literature, most of which—though not necessarily all—would be in the public domain. They are independent experts that are reviewing the available scientific information.

Senator SIEWERT: Is the information that they are reviewing solely from the manufacturers, or are there other independent sources of information?

Dr Healy: It could be a mix, and it may vary depending on the circumstances.

Senator SIEWERT: For the current process—the one that has just been undertaken in February—are you able to take on notice which of those relied on the manufacturer information?

Dr Healy: FSANZ does not hold that information. The health-based guidance values are established through the Office of Chemical Safety within the Department of Health, or through this international expert body. Because they are both expert bodies, we do not re-review the information.

Senator SIEWERT: So I need to ask the Office of Chemical Safety.

Dr Healy: Potentially, yes.

Senator SIEWERT: So you are not able to table the information that you relied on to do this particular review?

Dr Healy: For the values that we used that were set through the international expert body, we are able to point to the scientific monographs that have been published. They are available the WHO website. The values that have been set through the Office of Chemical Safety—I might need my colleague to help me here—are available on the Office of Chemical Safety website. I am not sure whether the monographs are publicly available. I would need to check.

Senator SIEWERT: Could you take on notice pointing us in the right direction to that website? Did you undertake and require any further information or studies on any of the MRL levels that were changed as part of this latest process?

Dr Healy: No. As I said, we have relied on the health-based guidance values that have been developed through the expert bodies that I have been describing. We, as FSANZ, undertook the dietary intake assessments.

Senator SIEWERT: Do you do the same thing as APVMA, which is relying on the assumption that chemical users will do what they are supposed to do according to the label?

Dr Healy: I will tell you what we do, rather than saying whether we do the same as APVMA. In determining whether the product is going to be safe, we take the MRL value and we assume that the maximum MRL is going to be applied across the foods where you may expect to find it. That is a very conservative assumption. We know it is conservative because our surveys of pesticides in the Australian food supply indicate that the levels that you find are very low.

Senator SIEWERT: Can you outline whom you consulted when you did undertook this last process?

Dr Healy: All FSANZ's proposed amendments to the standards are required to go through a full consultation process. That public consultation process was held in accordance with our legislation.

Senator SIEWERT: The actual report only seems to indicate consultation with industry. Which health professionals did you consult?

Dr Healy: The reports are available on the FSANZ website and are publicised. It is open to all stakeholders to make a submission.

Senator SIEWERT: Can you quickly take me through that process? You say you consult. They are on the website. How do people know that you are undertaking the process?

Mr McCutcheon: As soon as a proposal is prepared, we notify that to the public so everyone is aware that that new piece of work is on our work plan. The M1010 proposal you are referring to was done under the general procedure. Once we prepare a draft variation to the code, a call for submissions paper, that paper is again notified to the public and put into the public domain for comment.

Senator SIEWERT: Through the website?

Mr McCutcheon: Through the website. We have a notification circular that goes out on a regular basis to over 5,000 outlets.

Senator SIEWERT: You email them.

Mr McCutcheon: Anyone interested in MRLs can attach their name to that list. Once we receive those submissions, we prepare the report for the FSANZ board and the FSANZ board makes a decision. That decision, along with the report upon which the board made the decision, is then forwarded to ministers on the Australian and New Zealand Ministerial Forum on Food Regulation. The public are notified and that report is in the public domain. Once ministers have considered that report and if it is approved, then the amendments to the standard are gazetted, and again, there is a public notification for that. So there are at least four public notifications through the process of doing proposals and applications.

Senator SIEWERT: The process is: you put it out there and people respond. It is not actively going out and seeking various key groups, other than in an email.

Mr McCutcheon: It is up to groups to make submissions, but, when we prepare the final report for the board, that includes a list of all the submissions, the key issues that have been raised in those submissions and the FSANZ response. So, again, if someone puts in a submission, they would be able to see what the FSANZ response was to that submission.

Senator SIEWERT: I have got some very detailed questions which I will not ask now but I will put them on notice.

CHAIR: Thank you. That is all for FSANZ. I think there are some questions on palliative care.

Department of Health

[20:48]

Senator SIEWERT: I need some help because I may be reading this table wrongly. If I am, you will solve my problems quite quickly; if I am not, and I am reading it properly, we may be here a bit longer. I am after outcome 1 and table 1.1 on page 38. I also want to look at

the forward estimates. I am trying to find out how much is being spent on palliative care and whether it is going up or down. Let's put it that way.

Dr Southern: We will have to take that on notice—we have some information around funding for palliative care projects, but that obviously is not the full suite of funding for palliative care—unless I can find it in the PBS.

Mr Bowles: The specifics probably won't be in the PBS.

Senator SIEWERT: Maybe I can take you through our reasoning, and you can tell me whether we are reading it right or not. In outcome 1 Population Health there is an overall reduction—is that in the 2015-16 budget?

Dr Southern: Sorry; where are you looking, Senator? Outcome 1 covers a number of things; it is public health, chronic disease and palliative care.

Senator SIEWERT: Exactly. That is what I am trying to find out. Take me through how much is in the budget for 2015-16?

Dr Southern: For the whole of that outcome?

Senator SIEWERT: Yes.

Dr Southern: I am looking at that table on page 38. The whole of that outcome is a total of a bit over $200 million in 2014-15.

Senator SIEWERT: That is 2014-15, but what is 2015-16?

Dr Southern: It is $194.861 million.

Senator SIEWERT: I read that as a decrease in that funding—is that correct?

Dr Southern: Yes. That is what we are looking at, but, as I said, that is for the whole of that program.

Senator SIEWERT: What I am trying to find out is what component of that is palliative care? As I understand it, that is a decrease in 2014-15 as well.

Dr Southern: From 2013-14?

Senator SIEWERT: Yes.

Dr Southern: Sorry; I do not have those figures in front of me.

Ms Flynn: I will just point out that there is some money for palliative care in outcome 1 that funds national palliative care projects and then there is some other money that comes out of outcome 4 Acute Care where we fund state and territory governments because they are responsible for the delivery of palliative care services. It is in both outcomes.

Senator SIEWERT: Okay. I want to come back to that, if that is okay. Can we just go to this budget: looking at the 2015-16 budget, we have increases in funding to vaccination, screening, organ donation. What we are trying to work out is where, since some of those programs have increased, the cuts are going to occur.

Dr Southern: Looking at those gross figures, because there are so many components of program 1.1 getting to that level of granularity with what we have in front of us today is going to be a bit difficult.

Senator SIEWERT: You can probably appreciate that a lot of us have been doing a lot of work on palliative care. We want to know where those cuts are coming in and what it means to those programs.

Dr Southern: We can certainly take that on notice for you, to derive what the budget looks like between those years, but, as Ms Flynn was saying, there is also palliative care funding that comes out of outcome 4.

Senator SIEWERT: I want to go there in a sec; I just want to finish off this. I understand, Dr Southern, that what you have just said is that it appears you do not have the detail on what programs are being funded and where the cuts are coming in. I have to say I find this quite strange that you would not know where cuts are being made.

Dr Southern: Some of it will go to the discussion we have been having around flexible funds as well. We do have some information here about palliative care projects. As I mentioned, some of the information about the funding for those projects is over the next couple of years. We can certainly break down the palliative care in that respect.

Mr Bowles: Maybe I can help a little bit: I am not aware of any cuts to palliative care through flexible funds or anything else.

Ms Flynn: That is correct.

Mr Bowles: There are no cuts to palliative care that I am aware of.

Ms Flynn: I think it is important to distinguish the funding under Outcome 1, which is for projects that have a start and a stop, from the funding for palliative care services is in Outcome 4.

Senator SIEWERT: Okay, we will come back to that. I do understand what you mean by start and stop. If we are talking about projects with particular organisations, are there any changes to those particular projects?

Ms Flynn: No.

Senator SIEWERT: Can you take me through how the palliative care projects are progressing?

Dr Southern: In April last year Minister Dutton approved funding of up to $52 million for palliative care projects over the three-year period from 2014-15 to 2016-17. The funding levels over that period go from $14 million in 2014-15 to $18 million next year and $20 million the following year.

Senator SIEWERT: Do they remain in place?

Dr Southern: Yes.

Senator SIEWERT: Is there any other palliative care funding?

Ms Flynn: No, apart from the outcome 4 funding that we were talking about.

Senator SIEWERT: Can we go to outcome 4 funding? Can you split that up?

Mr Bowles: We are not going to be able to split that out. Outcome 4 is public hospital funding—is that what we are talking about? It is in the acute care bucket. We fund the states through the normal process for the acute care sector, and so we are not going to be able to break it out into different parts.

Senator SIEWERT: What is the problem with breaking it out?

Mr Bowles: The states obviously have responsibility for delivering all of that.

Senator SIEWERT: I think that was one of our recommendations. Which leads me to the question of where are we in responding to the Senate committee's inquiry?

Mr Bowles: Which particular inquiry?

Senator SIEWERT: The palliative care inquiry.

Mr Bowles: There are a few of them.

Senator SIEWERT: I know I jump around a bit, but I do not jump around quite that much.

Mr Bowles: There have been a few on public hospitals as well.

Dr Southern: The Department of Health is coordinating the Australian government response to the committee report, and it is currently with government for consideration.

Senator SIEWERT: Minister, that means that remains with you. How long has it been with the government?

Senator Nash: Could I take that on notice? We have so many at the moment and I would hate to give you the wrong date. Hopefully, it will be finalised in the not too distant future.

Senator MOORE: I want to follow up, Mr Bowles, on the issue of the acute care distribution. In the past there were funds given by the federal government to state governments and there was a range of areas they could spend it in; the Commonwealth could not tell them what to do. With the last big injection of funds, a lot of states went for rehabilitation programs rather than palliative care. Under the current system, can we find out how much states get for palliative care?

Mr Bowles: I can take it on notice to try to find out.

Senator MOORE: That would be good.

Mr Bowles: But I just caution there: because we fund based on activity based funding mechanisms, which could be either through the national efficient price or the national efficient cost, depending on whether it is a block or activity—

Senator MOORE: Yes, we went through that yesterday.

Mr Bowles: Yes, the stuff we went through.

Senator MOORE: Acute care.

Mr Bowles: Yes, acute care. It could be a little difficult for us to come up with an answer for that. But I will take it on notice and see what we can find out.

Senator MOORE: Can you see what you can get us and then we will attack it from the other side with the states as well. It seems to be one of those areas that is shady. If we could get that, that would be good.

Mr Bowles: Yes. It will be based on activity, I would suggest, and then you do have this difficulty between the activity basis and the block funded basis. We will take it on notice and have a look.

Senator MOORE: I want to have a quick look at the $52 million. I have a media release that the minister put out when she came to the Friends of End of Life group and talked about the process, and the $52 million is mentioned. The way the media release reads, it looks like it

was $52 million being announced on 26 May 2015. But, from what you have said, this is a bucket of $52 million that was actually over 2014-15, 2015-16 and 2016-17. Is that right?

Dr Southern: That is correct.

Senator MOORE: The media release—I will ask for more detail—listed the programs, all of which look really valuable and important, and I know most of them. I would like to get a little bit more detail on them. This is from the minister's media release on 26 May. Minister, I think it coincides with when you came and did the launch, which was really good, and I thought it was a very valuable event. Could we get a more fulsome list of the organisation, the programs and the projects? On the media release it is just who they were. It would be nice to get who they were, where they were, what the project is and how much it is. I have not be able to find that on the website. I am sure it is there somewhere but I just cannot find it.

Dr Southern: We can certainly take that on notice.

Senator MOORE: I think about nine or 10 projects have come under that box. I would like to know which of the organisations had previously received funding for palliative care projects—ongoing, that they have received it in the past—and how much the organisations previously got, if you can find that. How are they selected? This is a selection process, because this is grants to an extent. Was it a select tender or how was that done?

Dr Southern: it was an open, competitive invitation-to-apply process that was undertaken in the middle of last year.

Senator MOORE: These were part of the big round of grants?

Dr Southern: Yes.

Senator MOORE: I am more familiar with the DSS ones, but this was at the same time. Can we find the detail of when this was done?

Dr Southern: Mid-2014 is the impression I have got that it was launched.

Senator MOORE: We would like to know, if possible, how many organisations put in for this open tender. These were the successful ones. It is to get a sense of what is happening in the wider palliative care community.

Senator SIEWERT: And how much they asked for.

Senator MOORE: See what you can give us. I would also like to know where they are, because some are clearly national organisations and some state based. It would be nice to know where they are at in these processes. I would really like to think it was $52 million from May 2015, but it is probably the package from last year.

Dr Southern: No, it is from 2014-15.

Senator MOORE: Is there any more money? Is this the full extent of the $52 million? We have no idea with this particular document whether this is all the $52 million or whether it is some of it. The figures you read out were over a three-year period. If we could get that degree of funding, that would be very useful.

Senator McLUCAS: Secretary, following our discussion about the review into organ and tissue donation and the authority, can you provide for me—I am now being a lot more specific about the request on notice—the dates of meetings with ShareLife board members—

Mr Bowles: With me?

Senator McLUCAS: By all the senior executive, either collectively or individually.

Mr Bowles: Mr Cormack and I met with them once. I do not know the date, but we can take on notice when Mr Cormack and I met with ShareLife that once.

Senator McLUCAS: But if I put it on notice, I would like the rest of the executive to have a look at their diaries too.

Mr Bowles: The rest of the executive?

Senator McLUCAS: The senior executive of the department.

Mr Bowles: Only Mr Cormack and I met with them.

Senator McLUCAS: Meetings with ShareLife board members, either in their capacity as a ShareLife board member or in other capacities. I would like the same question answered for the minister and the minister's office. I would like, similarly, dates of meetings with Outcomes Australia board members.

Mr Bowles: I can tell you now that I have not met with them.

Senator McLUCAS: I will give you the opportunity to go and have a look at the membership of the board of Outcomes Australia.

Mr Bowles: Yes.

Senator McLUCAS: And the same, Minister, for you and your office. Has the department changed any announcement on its website about the budget measure on organ and tissue donation?

Mr Bowles: I do not know what you mean.

Senator McLUCAS: Anything that was originally put on the department's website about the budget measure on organ and tissue donation—from when it was first put up until now.

Mr Bowles: Not to my knowledge. As far as the budget goes, I cannot imagine why we would change the budget.

Senator McLUCAS: Any material about the measure—the $10.2 million for organ and tissue donation.

Mr Bowles: Can you be more specific?

Senator McLUCAS: An assertion has been put to me. That is all I can ask you.

Mr Bowles: I will take it on notice, but in relation to the budget—

Senator McLUCAS: It is not the budget itself. You cannot change that. I am not suggesting you changed the budget.

Mr Bowles: You think I have changed something about the budget on the website?

Senator McLUCAS: The assertion is that there has been commentary on the department's website, particularly about the numbers.

Mr Bowles: Okay.

Senator McLUCAS: Minister, on your website, your press release talks about a $20 million package. How is that different from the $10.2 million package?

Senator Nash: My understanding is that that was corrected. There was a typo. The original media release had the figure $20 million. Then we realised there was a typo and it was changed to $10.2 million from the $20.2 million.

Senator McLUCAS: When did that happen?

Senator Nash: I will have to come back to you on the actual date.

Senator McLUCAS: When I looked this afternoon, it still said $20 million.

Senator Nash: My understanding was that that was corrected—absolutely. But I am happy to take that on notice and come back with an explanation.

Mr Bowles: The minister's media release probably would have gone up on our website as well. I will check on the dates. That is usually what happens.

Senator McLUCAS: That is probably what I am talking about.

Mr Bowles: That is what you are talking about?

Senator McLUCAS: Probably. I would like to know when that amendment was made. Was it also amended, Minister, to accurately describe the use of '37 per cent' in your media release?

Senator Nash: It was indeed. There was some concern that the figure was not correct. Given that, the release was amended. That points to one of the reasons the review was important: there were conflicting views on the statistics. The original statistic, as I understand it, came from the Department of Health and the 2013 DonateLife report—the audit. That is my understanding. I am happy to get you more information on notice.

Senator McLUCAS: Including the date when any change has been made. I read it today. Unless I have been sent a cached copy of your—

Senator Nash: My understanding is that those two things were corrected, but I am very happy to take that on notice and let you know the dates.

Senator McLUCAS: Were there any other errors?

Senator Nash: Not to my knowledge, no.

Senator McLUCAS: Can I receive information about the date that the brief that includes the recommendation for a review was provided to the minister and the date the minister signed that brief or minute—I do not know what it would have been called?

Mr Bowles: I can tell you when we sent something but I cannot tell you when the minister saw it or signed it, so we would have to take that on notice. It was sent on 20 May.

Senator McLUCAS: Minister, do you recall the day you signed it?

Senator Nash: No, I would have to take that on notice for you.

Senator McLUCAS: So it was sent up on the 20th—

Mr Bowles: That is what is written on the top of this, yes.

Senator McLUCAS: Minister, when did you or your office first become aware that Channel 7 was going to do a story on organ and tissue donation?

Senator Nash: I would need to take on notice the exact date.

Senator McLUCAS: I have a subsequent question. When was the minister's office first contacted by Channel 7 seeking comment?

Senator Nash: Again I will take that on notice.

Senator McLUCAS: When was the interview that you did for that show filmed?

Senator Nash: Again I will take that on notice.

Senator McLUCAS: Do you recall where it was?

Senator Nash: I think I was in Cairns. I have been to four different states in the last week or so—

Senator McLUCAS: It was Cairns; I recognise the background. The Channel 7 story was broadcast on the 25th; is that correct?

Senator Nash: It was a Tuesday night of that week. I will take that on notice, but that would be publicly available.

Senator McLUCAS: I might be wrong there. The day after is the day you put out the press release.

Senator Nash: Again I will check those dates for you on notice and come back to you.

Australian Sports Anti-Doping Authority

[21:13]

CHAIR: We will now move to outcome 10—sport and recreation. We will start with ASADA. I understand Mr McDevitt is not joining us.

Mr Bowles: No. He has had a bit of an adverse reaction to some surgery, I understand.

CHAIR: We send our best wishes.

Senator LEYONHJELM: I want to understand to what extent ASADA is involved in sports, and which sports it prioritises. Do you have any understanding of public attitudes—evidence or surveys—on the extent to which sports fans want sports people to be drug-free?

Mr Burgess: Before I answer the question, I need to apologise on behalf of our CEO, who as of this morning was due to be here and was going to come here but he is under medical instructions to stay at home.

Senator LEYONHJELM: If there is anything that you feel you need him for, say so and we will put it on notice. It is no problem.

Mr Burgess: In answer to your question, ASADA undertakes stakeholder surveys once a year, particularly to gather information and views of athletes, disciplines, athlete support personnel and so on as to their attitudes towards drugs in sport. The responses to those surveys indicate a very high level of appreciation and satisfaction with the work that ASADA does, as well as indicating the expectation that they have on ASADA to ensure a pure, clean and level playing field for all athletes across Australia when they compete.

Senator LEYONHJELM: There are a lot of sports and there is only one ASADA and you have limited resources and so forth, so how do you prioritise?

Mr Burgess: We have coverage of approximately 84 sports across the country. All those sports are required to have anti-doping policies

Senator LEYONHJELM: Required by?

Mr Burgess: Required by legislation—sporting administration rules within the ASADA Act and the National Anti-Doping scheme, which is all part of ASADA legislation. Each sport is required to have an adjunct sports policy, which basically implements the NAD scheme and which also enshrines the World Anti-Doping Code. The sports vary from professional sports

through to Olympic sports—swimming, rowing, AFL, rugby league, athletics, triathlon and so on. We essentially prioritise on what we believe is a risk-based methodology, so each year we would assess the risk of doping amongst those sports and then prioritise accordingly with the tool kit of doping controls that we have in place. We basically are there to prevent, deter and detect, and based on those risk assessments that we undertake as part of our risk-based methodology, we would prioritise and intervene accordingly and spread those resources—mainly education, intelligence, investigations and testing—where we believe the greatest risk is. For example, where we believe there is a low risk of doping in a sport, we would basically prioritise education and awareness for the athletes of those sports. Where we prioritise a sport as being high risk, we would hit it with basically deterrence and detection testing, together with ensuring that we receive adequate intelligence to enable us to then target intelligence driven testing.

Senator LEYONHJELM: I think your answer to my first question was that the sports fans want sports people to be drug-free.

Mr Burgess: Correct.

Senator LEYONHJELM: And you have concrete evidence of that.

Mr Burgess: Yes.

Senator LEYONHJELM: So to what extent do the sporting codes have an incentive to institute and enforce drug bans independently of ASADA?

Mr Burgess: When you say independently, they themselves have obligations and responsibilities.

Senator LEYONHJELM: What I am asking is: if ASADA was not present, would the sporting codes have an incentive to maintain vigilance against doping?

Mr Burgess: It is a good question, and really it is probably a question you would ask the sport. In my opinion, and probably in ASADA's opinion, yes, they would have an incentive to be dope free for the same reasons I gave before: the integrity of their sport, their brand and their reputation. If the participants who go and watch those sports expect a dope-free sport, there would be some incentive there. However, do they have the resources to do that? Do they have the wherewithal? Do they have the sources of intelligence that we can obtain and the investigative skills we have? That is another question.

Senator LEYONHJELM: So the sports fans want their sports to be drug free; the sports administrators and the people running it have an incentive to be drug free; and ASADA brings resources and expertise to the table. To what extent could sporting codes opt out of ASADA oversight and maybe just utilise ASADA's facilities to administer their own compliance programs?

Mr Burgess: At the moment I do not think they have the choice to opt out under the legislation.

Senator LEYONHJELM: They do not.

Mr Burgess: If a sport wishes to be recognised as a national sporting organisation under the Australian Sports Commission, they are required to have in place an antidoping policy. To have an antidoping policy, they will fall within the Australian government's jurisdiction and the legislation on antidoping.

Senator LEYONHJELM: Is there a policy, or an international obligation—some of these sports being international—for the government to mandate drug-free status, or is it just the way things are done? Is Australia unique in requiring this regulated approach? That was a garbled question, I am sorry. Choose which one you want to answer and I will remember the rest of them for later.

Mr Burgess: I do not think Australia is unique. There are various models around the world—all of which, however, do demand an antidoping organisation. A number of those antidoping organisations are government run and funded. A number of those organisations, whilst they are funded by government, are independent organisations. For example, the antidoping organisation in the United States is funded by the United States Olympic Committee. That is one example, whereas in the UK it is funded by government and is a government organisation. New Zealand's is a government organisation.

Senator LEYONHJELM: Where I am heading with this is: the reason you are involved in this is because you have a legislated mandate. In countries that do not have a legislated mandate, is there any less or any more of a problem with drugs in sport?

Mr Burgess: That is a difficult one to answer without data before me.

Senator LEYONHJELM: Yes. So when you said there is an incentive for sports to comply, or to be drug free, based on their fans, what is the negative incentive? In other words, what are the consequences if they do not meet their antidoping obligations and do not have an antidoping policy? What are the legal implications for them under the legislation that guides your activity?

Mr Burgess: Sorry, what—

Senator LEYONHJELM: What are the risks—the legislative and regulatory risks—if they do not maintain a drug-free approach?

Mr Burgess: From what I understand they would not be considered a compliant sport insofar as—

Senator LEYONHJELM: What would that mean for them?

Mr Burgess: Their recognition as a national sporting organisation in Australia. Then possibly it might be a question for the Australian Sports Commission as to what it would mean in that regard, and it may well have implications for government funding of those sports.

Senator LEYONHJELM: Government funding, that is where I was heading with this. The logical thing would be that they would not be keen to be noncompliant with their obligations towards you guys because of the potential loss of government funding?

Mr Burgess: I think that would be one of the primary reasons. I think there would be other reasons.

Senator LEYONHJELM: I acknowledge your earlier point about the reputational stuff and the expectations of fans, so there is a positive incentive and negative incentive. I think I understand the situation. I might leave it there for now.

Senator PERIS: My questions are around a news article in *The Australian* on 13 May stating that ASADA has suffered an operating loss of $750,000 as a result of the Essendon

and Cronulla investigation. Are you able to inform us what the total cost so far is to ASADA, including legal costs, because of these investigations?

Mr Burgess: You are correct. At this stage we are forecasting an operating loss for this financial year of $750,000. The costs, which in the main represent legal costs, to this date are $3.9 million.

Senator PERIS: That $750,000 is operational and $3.9 million is additional to that?

Mr Burgess: No, the $750,000 would be included in that.

Senator PERIS: With that $3.9 million, are you able to breakdown those costs?

Mr Burgess: Yes, I can. The only other thing I would say is that $3.9 million represents our external legal costs. The other additional cost to that would be our internal costs, and in the main they would be for the investigation that was conducted. I do not think I have that number. I am happy to take that one on notice, but effectively it was five to six investigators over a period of about nine to 10 months.

Senator PERIS: You are able to break those down—but take it on notice?

Mr Burgess: We will take that one on notice.

Senator PERIS: Is ASADA providing assistance to WADA in the preparation of their case?

Mr Burgess: ASADA is supporting WADA.

Senator PERIS: Are you able to provide what assistance that would take?

Mr Burgess: ASADA is supporting WADA with support in kind. We have provided two lawyers for a small period of time to brief WADA, and WADA's legal representatives, to hand over the full brief of evidence. At the moment that is a couple of weeks work for two senior lawyers. And we have, at this stage, agreed with WADA to contribute a capped amount up to US $50,000.

Senator PERIS: Apart from that US $50,000 there is no other financial assistance apart from the support of the two lawyers?

Mr Burgess: Not at the moment.

Senator PERIS: There is speculation where the CAS hearing will be held. Will ASADA officials assist WADA in travelling to, and be present at, that hearing?

Mr Burgess: I do not think I can really answer that because that is some time into the future. ASADA legal representatives, at the moment, are helping with providing and handing over the full brief of evidence. They are not presenting the case to the Court of Arbitration for Sport—WADA legal counsel will be doing that—so whether they will be required or not is a matter for a future decision.

Senator PERIS: Do you believe that this case has led to an increased awareness of doping in sport amongst people involved in sport and amongst the general public? And if you do, what statistics do you have to support this?

Mr Burgess: I definitely think that it has increased awareness amongst athletes, participants and the general community—tremendously so. The statistics that I would use to support that, in addition to—as I mentioned earlier—those stakeholder surveys, would be statistics such as the increased levels of education that is being undertaken by athletes—we

have seen marked increases over the last few years; the increased awareness, with sporting organisations and athletes contacting ASADA for information; the increased access and hits to our website; and the increased use of our 'check your substances' online tool. I think generally this is not so much insofar as ASADA's increased statistics as the increased emphasis that a number of sports have put onto their own integrity units, particularly establishing integrity units.

Senator PERIS: Apart from you providing that information tonight, is that something that you put out publicly to inform people, the public, how much these cases have increased the awareness of drugs in sports?

Mr Burgess: In our annual report we do. I think that is probably the only source at this stage where we are promoting the awareness, in the sense of demonstrating the increased awareness through our annual reporting and though our website.

Senator PERIS: This leads me to the next question. In your opinion, what changes are required for ASADA to meet the changing nature of doping in sport? For example, would you assume fewer positive tests or more intelligent reports?

Mr Burgess: ASADA is, in a way, shifting its strategy as to how we operate as an antidoping organisation, consistent with the moves by other antidoping organisations, together with the shift and the greater emphasis in the World Anti-Doping Code on the need for antidoping organisations to capture and obtain quality intelligence and to conduct investigations. The world of antidoping is shifting. In ASADA we are putting more emphasis onto intelligence capturing and investigations but using that information particularly to undertake more targeted intelligence-driven testing.

Senator PERIS: To the answer you have just provided, will that require additional funding and resources?

Mr Burgess: It is always a good question, that one. I think organisations could always do with more, which would mean for us we could conduct more investigations and undertake more tests. But we live within our means. We live within the resources that are provided to us by government, and we think those resources, at the moment, are sufficient for us to maintain a good watching brief over sports.

Senator PERIS: I am not sure if you can help me with this, but I think Mr McDevitt travelled recently to Montreal?

Mr Burgess: That is correct.

Senator PERIS: Are you able to answer questions around that or is that something I will need to put on notice? It depends what it is?

Mr Burgess: I can try or I can take them on notice.

Senator PERIS: Are you aware of Mr McDevitt's recent trip to Montreal? Was it to lobby WADA on the need to appeal the AFL Anti-Doping Tribunal ruling in the Essendon case? It does mention in this article that he did travel there to discuss the Essendon matter but it was also to have meetings with the international antidoping officials. Can you elaborate on that?

Mr Burgess: Mr McDevitt went to Montreal for a period of, I think, three days in late April, at the invitation of WADA. It was to attend an ad hoc working group with eight other CEOs of antidoping organisations to discuss the effectiveness of antidoping organisations and

effective antidoping regimes. That was the purpose of the trip, and it was paid for by WADA. That was the purpose. The purpose was not to lobby WADA to take out an appeal.

Senator PERIS: If it was provided by WADA, would you be able to give us a cost breakdown of that trip?

Mr Burgess: I will have to take that on notice.

Department of Health

Australian Sports Commission

[21:35]

Senator XENOPHON: I have a number of questions in relation to the FIFA scandal, the FFA and related matters in terms of—I need some help from you, Chair. Do I refer to it as football or soccer for the purpose of this hearing?

CHAIR: I think these days they like it to be referred to as football, even if we grew up with soccer. You go with whichever you prefer.

Senator XENOPHON: I will refer to it as football but we know what we are talking about. Is it fair to say that football is a sport with high-participation rates that is also an Olympic sport which receives via the FFA a relatively large amount of government support compared to other sports that either do not have such high-participation rates in this country or are not Olympic sports? If you could please keep your answers short, and if you have to elaborate please do so on notice.

Mr J Smith: Just to clarify, are you seeking information about the funding that football receives relative to other sports?

Senator XENOPHON: Yes. Do you want to take that on notice?

Mr J Smith: The Sports Commission is the only government body that currently funds football for participation, so the Sports Commission would need to answer that question in terms of FFA's funding received.

CHAIR: We might bring the Sports Commission representatives to the table as well because we might be going back and forth.

Senator XENOPHON: Because of incredible time constraints on my part, if you can give me a short answer please do so, Mr Hollingsworth. I will repeat the question, how much government money does football get via the FFA?

Mr Hollingsworth: We fund football under our high-performance stream and our participation funding stream. The current funding for participation in 2014-15 was $916,000 and for high-performance the investment is in the vicinity of $2 million—I do not have the exact figure with me.

Senator XENOPHON: That is fine; you can take that on notice. Can you give me a comparison of two or three financial years before as well?

Mr Hollingsworth: The total investment is about $3 million.

Senator XENOPHON: Can you very quickly explain the formula for government funding for sport in Australia that results in this fairly generous funding for football? Is it based on participation rates? Is it the status as an Olympic sport? If you need to take that on notice, I understand.

Mr Hollingsworth: The funding for high-performance is focused exclusively on the Olympic domain for the men and women's—the Matildas. We do not fund Football Australia for the high-performance program for the Socceroos. We make a contribution to the junior programs and co-invest with Football Australia to produce outcomes at the Olympics, at junior world championships, and the women's World Cup and the Olympics for women. In participation, they receive funding to grow the game. We fund over 60 sports for participation and we invest in sports to grow their member base.

Senator XENOPHON: I think you have answered nearly $3 million this financial year?

Mr Hollingsworth: That is correct?

Senator XENOPHON: How much approximately for next financial year?

Mr Hollingsworth: We are just going through the investment process now, it has not been finalised.

Senator XENOPHON: In relation to the FFA bid for the 2022 World Cup, is it the case that the Australian government gave the FFA some $45 million for the bid? I note a report on the ABC tonight that 1,200 people have died in Qatar in the building of the stadiums.

Mr J Smith: The total amount provided was $42.25 million.

Senator XENOPHON: Okay. Can you, on notice, provide details of what amounts over what financial years were these funds given?

Mr J Smith: I can provide that now if you like. I have a breakdown by progress reports with six different payments over the course of a couple financial years that I can spell out for you quickly.

Senator XENOPHON: That is okay. I am happy for you to provide that on notice—is that okay?

Mr J Smith: Sure.

Senator XENOPHON: I am just trying to get through this expeditiously. Were the government funds provided to the FFA for the World Cup bid in addition to the regular funding for football at that time?

Mr J Smith: Yes.

Senator XENOPHON: In those years when the bid was funded by government, how much other money was given to the FFA for support of football besides the bid money? Was it just the regular funding, the sorts of things that Mr Hollingsworth was referring to—and I think he is nodding? Were there any other funds other than the streams that Mr Hollingsworth has referred to and the FFA and the World Cup bid money—is that right?

Mr J Smith: It is possible there were additional funds provided in those specific years. I could take that on notice and get more detail for you.

Senator XENOPHON: I am happy with that. I am just trying to get an overall picture. In relation to the bid money, given that there were taxpayer dollars involved, what governance, oversight, probity or other conditions were linked to that money and how it could be spent? Is that something that is readily available in terms of the documents relating to the issues of the probity, the conditions, the oversight, the governments and the like?

Mr J Smith: I can go through that if you like; the process in relation to the management of that funding agreement.

Senator XENOPHON: Can you provide documents in response to that as well?

Mr J Smith: There are a number of documents publicly available already—the progress reports and the final report that was released.

Senator XENOPHON: I do not want you to spend time on something that is publicly available. If you can direct me to that, that will be fine. But if you can focus on probity and governance and give us a quick outline of that now?

Mr J Smith: Absolutely. The funding agreement for the World Cup bid contained detailed reporting requirements that included a total of six progress reports over the period of a couple of financial years. Those progress reports reported against budget—

Senator XENOPHON: Are those progress reports publicly available?

Mr J Smith: Certainly the final report is and I will check on the other ones.

Senator XENOPHON: Yes, if you could provide those as well?

Mr J Smith: Absolutely. I will take that on notice. The progress reports reported against agreed bid milestones and it included detailed bid expenditure against budget line items. The department scrutinised material and had the opportunity to clarify and seek additional information, which it did on occasion. Payments were made only upon acceptance of those reports. Independent audited financial statements were required in the financial year 2009-10 and the final report included financial statements for the entire project period.

Senator XENOPHON: If you could, on notice, provide details of those progress reports if they are not already publicly available or affirming as to whether they are publicly available? Mr Smith, you have seen the reports of arrests and charges against some 14 individuals, including high-ranking FIFA officials and former officials, for money-laundering and embezzlement up to $150 million. That was in the indictments issued by the US Attorney General Loretta Lynch through her office. I take it you are aware of those reports?

Mr J Smith: Yes.

Senator XENOPHON: You would have to have been in a cave not to be aware of them. Are you aware of the almost $500,000 paid to CONCACAF, the Confederation of North, Central American and Caribbean Association Football in 2010 by FFA, ostensibly for a stadium upgrade?

Mr J Smith: Yes, I am aware of that.

Senator XENOPHON: That is an amount of money that went to the then Caribbean soccer supremo Jack Warner, who is facing indictment on other charges.

Mr J Smith: That was a payment that was made by FFA out of FFA funds. My understanding is that the payment was made to CONCACAF for the upgrade of the centre of excellence in—somewhere in CONCACAF; sorry, I do not have that detail.

Senator XENOPHON: I think Trinidad and Tobago.

Mr J Smith: Correct. That funding was then misappropriated once received by CONCACAF. The payment was not made directly to Mr Warner, is my understanding.

Senator XENOPHON: But can you link those funds? Were those taxpayer funds, that $500,000, related to the funding for the World Cup bid? There was a link between the two—was there not?

Mr J Smith: No. The $500,000 was not from the $42.25 million that I outlined earlier; it was from FFA's own source funding.

Senator XENOPHON: You are certain about that?

Mr J Smith: Yes—

Senator XENOPHON: That is fine. In terms of broad governance issues, in that the FFA does get from taxpayers ongoing funding in addition to the bid funding, do these allegations that the money was not spent as intended concern you?

Mr Stuart: We are aware that there is some fairly fishy business associated with these bids.

Senator XENOPHON: That has to be the understatement of the night.

Mr Stuart: But, I do not think it is appropriate for you to ask the official, Mr Smith, if he is concerned. We are here to answer questions of fact as well as we can.

Senator XENOPHON: Well it is appropriate, respectfully, in the context of having probity in governance frameworks and whether those probity in governance frameworks were in any way breached. That is a matter of fact isn't it?

Mr Stuart: Yes, sure. What I would like to say to you in response to that is that Jay has been able to step through the usual processes—

Senator XENOPHON: I am not being critical of Mr Smith at all.

Mr Stuart: No; let me finish—about the process of Australian government funding to the FFA, the process of reporting and the process of acquittal. In my discussion with Mr Smith earlier he has been able to tell me quite clearly that he is very satisfied about the government processes and the governance of Australian government funding to the FFA. The questions that you are asking, about the payments, are more appropriately addressed to the FFA.

Senator XENOPHON: Let us see about that. Given that the FFA does rely on a significant degree of government funding—and I am not critical of that at all—and given that there was a significant amount of funding for the FFA in the context of the World Cup bid, which was a massive amount of funds in the scheme of things, and there are serious allegations coming out of the United States about Mr Warner's use of funds and Australian funding of that, if that points to governance issues within the FFA—and I am not being critical of the FFA—or some breakdown in governance or probity issues about this money, is that not something that would set off potentially alarm bells? If they made a mistake—I am not saying that it was in any way deliberate—or erred in the way that those funds were acquitted, does that raise broader issues in the context of how the FFA manages its finances?

Mr Stuart: I understand where you are going.

Senator XENOPHON: That is the context. On that basis, given the recent very serious allegations against Mr Warner and the half a million dollars of Australian FFA funds by the co-mingling of Federal government funding, has this matter being referred to the Auditor-General or the AFP for further investigation? It either has or it has not.

Mr Stuart: Not by the department.

Senator XENOPHON: Not by the department?

Mr Reid: You use the word 'co-mingling'. I do not believe the department is aware of any evidence of co-mingling of Commonwealth funds with FFA funds for the purposes of these payments to CONCACAF.

Senator XENOPHON: Will the department examine the spending of other bid money given these allegations that money that was meant to go for something was not spent for that? Would that trigger an investigation by the department to say if there were governance issues in respect of that. Again, I am not being critical of the FFA but given these very serious allegations that have arisen out of the US will there be a closer examination of the spending of the $42.25 million of the bid money to ensure that it was appropriately spent in accordance with what it was meant to be spent for, because this half a million dollars for the Trinidad and Tobago sporting upgrades apparently went into Mr Warner's pockets. You can see the strand in relation to that. So can you tell me whether the department will at least look at that in the context of these recent very serious allegations?

Mr Stuart: That is a future-oriented question and I do not think we are going to have a discussion within the department about whether we will or will not do that right now.

Senator XENOPHON: Have you considered it to date? Let us not look at the future. I do not want to be futurist here. Let us look at the issue. Given the serious allegations, has there been consideration given to having a closer look at where the $42.25 million went; whether in fact some people involved in the bid process—I am not suggesting the FFA—have conned the FFA and by extension Australian taxpayers?

Mr Reid: The AFP has told the department that it is assessing the allegations that have been made. The department will cooperate in any process that the AFP takes part in. If there were going to the allegations as to whether Commonwealth money had gone astray and been misused, then the appropriate time to look at that would be after the AFP has done what it is going to do.

Senator XENOPHON: If I could refer you to the *Trinidad Express*—I am not suggesting that you subscribe to the *Trinidad Express*—their article of 30 May 2015 talks about this particular donation. I am very happy to provide you with a copy of the *Trinidad Express* article, perhaps through the committee. What I am trying to establish is if there was a suspect transaction involving the FFA—again, I am not suggesting that the FFA had any direct knowledge or intent in this regard; I am not suggesting they have breached Australian law. If there was funny business going on there—we have heard the allegations in terms of the bid for 2018 and 2022—given these recent very serious allegations, the charges that have been laid, the involvement of the US Attorney General, irrespective of what the Federal Police says, the yellow cards or the red cards have been raised here, so have you considered looking at it further? Will you look at it further, given the serious allegations?

Mr Stuart: I think we will need to see what comes out of the current investigations. We will cooperate very fully with whatever investigations take place. Mr Reid I think has appropriately said that we will look at and rely upon anything which is produced. But, at this particular moment, there is no chain of funding or chain of control between the federal

government funding and the money which was misplaced into Mr Warner's account—there is no link there.

Senator XENOPHON: In terms of the bid money, that $42.25 million, you will not be looking at that further at this stage?

Mr Stuart: It was fully acquitted at the time and there is not at this point—

Senator XENOPHON: You are satisfied with that acquittal?

Mr Stuart: We were satisfied with that acquittal at the time and there is at the moment no specific allegation of any kind relating to that funding.

Senator XENOPHON: I am very grateful to you.

CHAIR: On other issues; Senator Peris?

Senator PERIS: There was an article in yesterday's paper by Samantha Lane on a funding boost for elite sports. Can you confirm the accuracy of that story? Are you aware of it?

Mr Hollingsworth: I am aware of the article in the paper yesterday. As the article said, there are still decisions pending within the process before a final decision about the grants, so I am not in a position to confirm the final amounts of funding for sports and athletes.

Senator PERIS: The article says that $2 million worth of funding was allocated. Are you able to advise how this funding model came up with winners and losers?

Mr Hollingsworth: I can talk about the funding model for high performance more generally, if you would like.

Senator PERIS: Okay.

Mr Hollingsworth: Effectively, after the 2012 Olympics, which were not as satisfactory as we would have liked—you are aware that we overhauled the approach we have taken to high-performance sport and introduced a new game plan for high performance called Australia's Winning Edge. That was really about saying that there is an Australian government investment made through the AIS into sports for high-performance outcomes, and there is a clear expectation that sports need to contribute to those outcomes at some point over an eight-year cycle. Matthew Favier, the Director of the AIS, and the AIS conducted performance discussion sessions with any sport that was interested in high-performance funding. They could put forward their case as to how they could contribute to the targets, whether they are Olympic, world championship or Commonwealth Games, and then that is accompanied by an analysis around the need based on the realistic assessment of whether that contribution to the target is going to be achieved, and then a funding profile attached to that sport. That was set after the 2012 Olympics, and we made significant adjustments in both years 1 and 2 of that program. We are now 12 months out from the Rio Olympics and Paralympics. Therefore, it does not make sense to make a lot of funding changes to sports. However, it is an ongoing process. If there is a case for a change in investment for any individual sport based on where they currently sit and their needs, then there will be an adjustment made on that basis. We are going through that process at the moment. Once the final decisions are made, we can confirm what the funding profile is for the individual sports.

Senator PERIS: The sports that were identified in the clip yesterday, the winners—softball, baseball, cycling, table tennis—that was an internal decision that was made?

Mr Hollingsworth: There are a range of processes that have to occur before a final decision is made about the funding profile. There is an assessment made by management and management makes a recommendation to the board and the board makes a recommendation to the minister. That process is ongoing. Once that process is finalised and confirmed, the announcement will be made by the Minister for Sport around the funding allocations.

Senator PERIS: The minister in the article said that she is preparing to announce next week a new, simpler investment model for sports participation. Are you able to elaborate on that?

Mr Hollingsworth: I can certainly talk about the approach we are taking to the investment model which is around participation. Mr Thomson, who heads that area, can talk in a bit more detail, if required. Effectively, not unlike high-performance sport, we invest in about 60 sports for participation outcomes. We are introducing a new categorisation model which simplifies the current approach. Effectively, there is a set number of categories for sports that they sit in, and then like sports are funded to a similar amount. That model is based around membership data that the sports provide to us and also data on sports participation that is developed through the ABS. The Sports Commission has announced that it is in the process of working towards introducing a new national participation survey. A tender process is currently underway for a provider for that. That then will have new results for participation next year. At the moment we rely on ABS data, which is imperfect in some senses. Hence, we are going to a new survey. That model will apply from 2015-16 in terms of the application of funds to sports for participation.

Senator PERIS: Just going back to the $2 million that was mentioned. Is this additional, new funding, or has it been drawn from other areas of the Australian Sports Commission?

Mr Hollingsworth: Our funding profile was announced in the federal budget and has been maintained for our investment in sports and for our athletes. Locally, our investment since London has been focused on prioritising resources in the commission.

Senator PERIS: On page 136 of Budget Paper No. 4 it talks about a staffing level reduction of 26. Have you identified which areas these reductions in staffing levels will come from?

Mr Hollingsworth: That number refers to the change in average staffing levels between this financial year and next financial year. The answer is yes; we have identified that. That relates to the impact of the change from the Active After-school Communities program to the Sporting Schools program. The Sporting Schools program started on 1 January. It is by the calendar year and has a different staffing profile to the active after-school program. The change in the staffing profile primarily reflects a change and reduction as a result of the changing profile of the Sporting Schools versus the Active After-school Communities programs. That process has already been completed, so the staffing profile is in place.

Senator PERIS: It has already happened?

Mr Hollingsworth: Yes.

Senator PERIS: Were they made redundant?

Mr Hollingsworth: There were no redundancies. All of the Active After-school Communities workforce were on fixed-term contracts. We went through a competitive process and, of the 80 positions that exist within the Sporting Schools program, 54 of them

were people that were employed under the Active After-school Communities program and the remainder were new employees, or staff who had moved across from within the organisation.

Senator PERIS: Women on boards—Samantha Lane wrote an article on 10 May about female representation on boards claiming that there are large numbers of boards that currently fall short of the 2015 target of 40 per cent female representation. Can you provide background on the 40 per cent target and an update on the situation—how many sports currently exceed the 40 per cent target and how many do not?

Mr Hollingsworth: The Sports Commission has been very keen to promote the role of women in sport both on boards and in administration. As you would know, the Sports Commission invests for outcomes in its athletes and we are very proud that 50 per cent of our total funding for athletes goes to female athletes; 50 per cent of our dAIS funding. We would like to see more females in leadership positions in administration and on boards. As part of our ASC governance principles, we advocated for a target of 40 per cent of women on boards for sports. I found the article by Ms Lane quite disappointing because it actually undersold what has been achieved over the past two years. We introduced this target in 2013 as part of our governance principles. Since that time, the average representation at NSO board level in our top 15 sports has risen from 29 per cent to 38 per cent, which is a really significant improvement. There are some differences between individual sports. Just to highlight a few, of those 15 sports we have eight that are effectively compliant—some of them are at 38 per cent but they can only be at either 38 per cent or 46 per cent because of the numbers of people actually on the board, so we regard those as compliant. Eight are compliant; four have had an increase since we introduced the target but are not yet at 40 per cent—they are on their way; and three have decreased. Rowing has gone down from 38 per cent to 33 per cent, but is nonetheless still above 30 per cent, which is encouraging; swimming is only at 22 per cent, so they need to do some work there, and we have highlighted that in our report; and the Paralympic Committee has the lowest representation, and that was highlighted by Ms Lane in the article.

Senator PERIS: What assistance do you provide to these organisations to meet the target?

Mr Hollingsworth: Obviously the governance of an organisation is ultimately up to the organisation in and of itself and we encourage the sports to put in place a nominations committee that will encourage applications from sports and assess the skills mix of the board, including the gender mix—we encourage that. It is ultimately up to the sports and the member states that appoint the board. We feel that there is a momentum for change that is occurring across sports, noting the numbers I just spoke about. Other sports, I am sure, will follow suit when they see the example other organisations have been setting.

Senator PERIS: You said it was up to the sports whether they take on board these targets. Is it almost like name and shame—not a name and shame, but you see other sports like hockey that have got the highest, so how do you push them harder to get that target up?

Mr Hollingsworth: In our annual *Sports tally* report we do report on that benchmark so that sports that are underperforming are noted.

Senator PERIS: How much is being budgeted for the implementation of the Play.Sport.Australia program?

Mr Hollingsworth: Play.Sport.Australia is being met within our existing funding profile. Effectively, Play.Sport.Australia in the participation space is not dissimilar to Australia's Winning Edge. We refer to it as being a sister document in a way, and in many ways it overlaps with Australia's Winning Edge. It is around the themes and areas of focus that the Sports Commission will be prioritising—in terms of focusing on participation. We have not prioritised additional funding. What we have done, though, is say that we are going to focus our funding on the three themes that are captured in the strategy.

Senator PERIS: What were those three themes?

Mr Hollingsworth: We want to see more Australians, particularly young Australians, doing sport more often. We want to see our sporting organisations thrive. We want to see the sports that we are investing in growing. We also want to see sports being well run organisations. Through that we are going to focus on three areas. We are going to focus particularly on young Australians—that is the Sporting Schools focus. We are focussing on providing sector insight, research and analysis. Then we do a lot of business capability work through Mr Thomson's area, trying to help sports become better organisations, which includes governance and commercial technology—those sorts of areas. They are our areas of focus.

Senator PERIS: What was the total budget for the implementation of this program?

Mr Hollingsworth: Our total spend on participation outcomes is in the portfolio budget statements. In 2015-16 it will be $83 million.

Senator PERIS: What is the breakdown on the development of the website and promotional material? Do you have a breakdown of that for Play.Sport.Australia, where you gave me the full budget? What is the breakdown of the website promotional material?

Mr Hollingsworth: In relation to Play.Sport.Australia, there has been no additional spend currently on a new website for the site. We are considering some opportunities to promote the value for Australians of sport and participating in sport, as part of that. That is being contemplated as part of our approach of raising awareness of the importance of physical activity for Australians, and also the value of sport that it offers for a whole range of people across the Australian community, ranging from volunteers and officials to, obviously, participants.

Senator PERIS: You have just spoken about what your vision is for this program. How do you obtain the data to look at whether this program is going to be successful? How do you collect that?

Mr Hollingsworth: Maybe I could cover the three areas. On the first one, more Australians, particularly young Australians, participating in sport. We currently use the ABS data, as I mentioned before. That will be measured through the new AusPlay survey, which will begin later this year. It will be a definitive source of information to measure that global participation level, sport by sport. We rely on sports to provide their membership data to us to understand what their membership base is.

Senator PERIS: How often do you collect that data from the sports?

Mr Hollingsworth: Annually. Then, in relation to whether sports are well performing organisations, we run our annual sports performance review and we measure how sports are performing across the metrics of governance, finance, high performance and participation. We give each sport a rating.

Senator PERIS: Sporting Schools was first announced last year, in May 2014, and it was due to commence in January 2015. Last week the minister announced that grants were now open. When will the first round of grant funding be announced, and how will they be assessed?

Mr Hollingsworth: I might ask Mr Thomson to answer that.

Mr Thomson: The funding round, as you rightly noted, opened on 25 May. The funding round will close on 26 June. Over the course of that period, and as we reach the end of the period, we will assess the applications for funding. There are some pretty clear criteria around funding in terms of the size of schools, the number of children and how many times they will be participating in sport during the period.

Senator PERIS: Do you take the demographics into consideration?

Mr Thomson: The program has a wide range of opportunities for schools both in metro and rural and regional areas. Certainly, what we are seeing already from the transition period that we ran this term was that about 40 to 50 per cent of schools are out of regional or rural, which is consistent with what we saw out of the active after school program as well.

Senator PERIS: Will a full list of successful schools and organisations be made publicly available?

Mr Thomson: We do not necessarily have any plans to do so, but it maybe is something that we consider as we progress through the process.

Senator PERIS: How about the list of unsuccessful schools?

Mr Thomson: I think it is highly unlikely that any school will be unsuccessful. We will work with the schools to make sure that they are able to deliver programs in schools.

Senator PERIS: Mr Hollingsworth, how is the scholarship situation at the Australian Institute of Sport? Has there been an increase in the uptake of scholarships across all the sports?

Mr Hollingsworth: The model has changed, so there is no such thing now as an AIS scholarship as it originally existed. One of the big changes out of Australia's Winning Edge strategy was that the AIS effectively exited running programs on behalf of sports. You are no doubt familiar with the old program under which effectively what happened was that the AIS would withhold a portion of a sport's high performance funding and spend that money on behalf of the sport to run a program. It could be here in Canberra, although hockey was in Perth.

Under the new model, our view is that in a contemporary sports system, a sport should be running its own high performance program and the AIS should focus on adding value to athletes and sports in other areas, particularly in sports science and sports medicine. What we now have is the concept of an AIS supported athlete—an athlete supported through the Direct Athlete Support program, or DAS. That program currently gets $12 million a year, which goes to about 750 athletes around the country based on a set of criteria—where the athlete is up to in their development. It is a little bit different from the old scholarships, but you can say with confidence that those are 750 athletes who are supported by the AIS. Under the old system, they would have been described as 'scholarship athletes'. We now call them DAS supported athletes.

Senator PERIS: Is that $12 million for 2014-15 or 2015-16?

Mr Hollingsworth: That was the amount for 2014-15. We are confident the amount for 2015-16 will be similar.

Senator PERIS: Do you have the 2013-14 allocation with you?

Mr Hollingsworth: What I can tell you is that over the last two years we have increased that amount. It is currently about $12.1 million. That was a 43 per cent increase over the amount we had before Winning Edge. I cannot do my maths backwards, but it would have been 43 per cent less the previous year—about $8 million.

Ms Johnstone: That is for the Australian Sports Commission's investment.

Senator PERIS: That change in the model you were talking about—what used to happen with AIS athletes here in Canberra—was that something that the Australian Institute of Sport thought internally was a better way of supporting athletes?

Mr Hollingsworth: We went through a process post London. If you remember back to the establishment of the AIS—it was established on the back of what was perceived as a failure at the Olympics in 1976 when we won no gold medals and only five medals in total. Five years later the AIS was established. It was a different system then. The sports did not have significant amounts of money. They did not run high performance programs. The concept of a centralised program with all the athletes coming to Canberra to live and train was introduced. Over time that changed. What was very interesting was that, by the time we got to 2012, the sport that was the most successful in London was sailing, which won three gold medals. They did not run a separate AIS program. Basically, AIS and Yachting Australia co-invested in a program and ran that. Cycling was similar and hockey was not dissimilar. The view was taken at the time that that was the better approach to follow. The idea was developed, taken to the board, discussed by the board and then, obviously, endorsed by the minister at the time—and it has been supported by subsequent ministers. We are hoping it will achieve some success next year in Rio.

CHAIR: Thank you very much, Minister, and thank you to all the officials, the committee secretariat, Hansard and other support staff.

Committee adjourned at 22:14