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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Wednesday, 23 October 2019

HEALTH PORTFOLIO

In Attendance

Senator Colbeck, Minister for Aged Care and Senior Australians, Minister for Youth and Sport

Department of Health

Whole of Portfolio

Ms Glenys Beauchamp PSM, Secretary
Professor Brendan Murphy, Chief Medical Officer
Mr Matt Yannopoulos PSM, Deputy Secretary, Corporate Operations Group
Ms Caroline Edwards, Deputy Secretary, Health Systems Policy and Primary Care Group
Ms Penny Shakespeare, Deputy Secretary, Health Financing Group
Adjunct Professor John Skerritt, Deputy Secretary, Health Products Regulation Group
Dr Lisa Studdert, Population Health, Sport and Aged Care Royal Commission Taskforce Group
Mr David Hallinan, Acting Deputy Secretary, Ageing and Aged Care Group
Mr Paul McCormack, Acting First Assistant Secretary, Financial Management Division
Mr David Hicks, Acting Chief Financial Officer, Financial Management Division
Mr Bernard Philbrick, Acting Chief Budget Officer, Financial Management Division
Ms Rachel Balmaino, First Assistant Secretary, People, Communication and Parliamentary Division
Ms Stefanie Janiec, Assistant Secretary, Ministerial, Governance and Cabinet Branch, Communication and Parliamentary Division
Ms Jodie Grieve, Assistant Secretary, Communication and Change Branch, Communication and Parliamentary Division
Ms Jackie Davis, General Counsel, Legal and Assurance Division

Outcome 1

Ms Angela Wallbank, Acting First Assistant Secretary, Portfolio Strategies Division
Ms Emma Wood, Assistant Secretary, International Branch, Portfolio Strategies Division
Ms Fifine Cahill, Assistant Secretary, Health Infrastructure Branch, Portfolio Strategies Division
Ms Bronwyn Field, Assistant Secretary, National Health Reform Branch, Portfolio Strategies Division
Mr Paul McBride, First Assistant Secretary, Health Economics and Research Division
Dr Masha Somi, Assistant Secretary, Office of Medical Research, Health Economics and Research Division
Ms Adriana Platona, First Assistant Secretary, Technology Assessment and Access Division
Ms Louise Clarke, Assistant Secretary, Office of Health Technology Assessment Policy Branch, Technology Assessment and Access Division
Mr Daniel McCabe, First Assistant Secretary, Provider Benefits Integrity Division
Mr Simon Cleverley, Assistant Secretary, Digital Health and Services Australia, Provider Benefits Integrity Division
Mr Tim Kelsey, Chief Executive Officer, Australian Digital Health Agency
Ms Bettina McMahon, Chief Operating Officer, Australian Digital Health Agency
Professor Anne Kelso, Chief Executive Officer, National Health and Medical Research Council

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Mr Tony Krizan, Economic Director and Chief Financial Officer, National Health and Medical Research Council

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Ms Bronwyn Field, Assistant Secretary, National Health Reform Branch, Portfolio Strategies Division
Mr Paul McBride, First Assistant Secretary, Health Economics and Research Division
Mr Mark Roddam, First Assistant Secretary, Mental Health Division
Ms Valerie Spencer, Assistant Secretary, Mental Health Services Branch, Mental Health Division
Ms Rebecca Claremont, Acting Assistant Secretary, Mental Health Services and Evidence, Mental Health Division
Ms Joanna Da Rocha, Assistant Secretary, Suicide Prevention and Mental Health Policy Branch, Mental Health Division
Mr Simon Cotterell, First Assistant Secretary, Primary Care Division
Ms Louise Riley, Assistant Secretary, Primary Health Reform and Palliative Care Branch, Primary Care Division
Mr Martin Rocks, Assistant Secretary, Primary Health Networks Strategy Branch, Primary Care Division
Ms Lyndall Soper, Acting First Assistant Secretary, Population Health and Sport Division
Ms Tiali Goodchild, Assistant Secretary, Preventative Health Policy Branch, Population Health and Sport Division
Mr David Laffan, Assistant Secretary, Alcohol Tobacco and Other Drugs Branch, Population Health and Sport Division
Ms Elizabeth Flynn, Assistant Secretary, Youth Taskforce, Population Health and Sport Division
Mr David Paull, Assistant Secretary, National Cancer Screening Register, Cancer, Hearing and Program Support Division
Ms Alice Creelman, Assistant Secretary, Cancer, Policy and Services Branch, Cancer, Hearing and Program Support Division
Ms Fay Holden, Acting First Assistant Secretary, Health Workforce Division
Ms Lynne Gillam, Assistant Secretary, Health Workforce Reform Branch, Health Workforce Division
Ms Chris Jeacle, Assistant Secretary, Rural Access Branch, Health Workforce Division
Mr David Meredyth, Acting Assistant Secretary, Health Training Branch, Health Workforce Division
Dr Andrew Singer, Principal Medical Adviser, Health Workforce Division
Dr Susan Wearne, Principal Medical Advisor, Health Workforce Division
Ms Christine Morgan, Chief Executive Officer, National Mental Health Commission
Ms Maureen Lewis, Deputy Chief Executive Officer, National Mental Health Commission

Outcome 3
Ms Lyndall Soper, Acting First Assistant Secretary, Population Health and Sport Division
Mr Andrew Godkin, First Assistant Secretary, National Integrity of Sport Unit
Ms Lara Musgrave, Assistant Secretary, Office for Sport, Population Health and Sport Division

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Ms Kate Palmer, Chief Executive Officer, Sport Australia
Mr Peter Conde, Chief Executive Officer, Australian Institute of Sport
Mr Luke McCann, General Manager, Corporate, Sport Australia
Mr David Sharpe, Chief Executive Officer, Australian Sports Anti-Doping Authority
Mr Brian McDonald APM, Deputy Chief Executive Officer, Operations, Australian Sports Anti-Doping Authority
Ms Rebecca Tyler, Chief Financial Officer, Australian Sports Anti-Doping Authority

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Mr Simon Cotterell, First Assistant Secretary, Primary Care Division
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Ms Jenny Francis, Principal Legal and Policy Adviser, Health Products Regulation Group
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Mr James Scott, Chief Regulatory Officer, Regulatory Services, Australian Radiation Protection and Nuclear Safety Agency
Mr Niraj Pau, Chief Financial Officer, Australian Radiation Protection and Nuclear Safety Agency
Mr Tone Doyle, Chief of Staff, Office of the Chief Executive Officer, Australian Radiation Protection and Nuclear Safety Agency
Dr Ken Karipidis, Assistant Director, Health Impact Assessment, Radiation Health Services, Australian Radiation Protection and Nuclear Safety Agency

**Outcome 6**

Mr Mike Callaghan AM PSM, Chairman, Aged Care Financing Authority
Ms Helen Grinbergs, Acting First Assistant Secretary, Aged Care Royal Commission Taskforce
Mr Chris Carlile, Assistant Secretary, Hearing and Disability Interface, Cancer, Hearing and Program Support Division
Mr Jaye Smith, First Assistant Secretary, Residential and Flexible Aged Care Division
Mr Nigel Murray, Assistant Secretary, Funding Policy and Prudential Branch, Residential and Flexible Aged Care Division
Mr Graeme Barden, Assistant Secretary, Residential and Flexible Care Branch, Residential and Flexible Aged Care Division
Mrs Jo Mond, Assistant Secretary, Dementia and Supported Ageing Branch, Residential and Flexible Aged Care Division
Ms Celia Street, Acting First Assistant Secretary, Aged Care Strategic Policy Division
Ms Emma Gleeson, Assistant Secretary, Aged Care Regulatory Policy Branch, Aged Care Strategic Policy Division
Ms Ailsa Borwick, Assistant Secretary, Aged Care Strategic Policy Branch, Aged Care Strategic Policy Division
Mr Charles Wann, First Assistant Secretary, Aged Care Reform and Compliance Division
Dr Bernie Towler, Medical Officer, Aged Care Reform and Compliance Division
Mr Anthony Speed, Acting Assistant Secretary, Aged Care Compliance Branch, Aged Care Reform and Compliance Division
Ms Kate McCauley, Assistant Secretary, Aged Care Portfolio Oversight, Aged Care Reform and Compliance Division
Ms Amy Laffan, Assistant Secretary, Aged Care Regulatory Design and Implementation Branch, Aged Care Reform and Compliance Division
Dr Nick Hartland, First Assistant Secretary, In Home Aged Care Division
Mr Travis Haslam, Assistant Secretary, Home Care Branch, In Home Aged Care Division
Ms Alison McCann, Assistant Secretary, Aged Care Access Branch, In Home Aged Care Division

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Mrs Christina Bolger, Executive Director, Regulatory Policy and Performance, Aged Care Quality and Safety Commission
Ms Shona Reid, Executive Director, Aged Care Complaints Resolution Group, Aged Care Quality and Safety Commission
Ms Ann Wunsch, Executive Director, Quality Assessment and Monitoring Group, Aged Care Quality and Safety Commission

Committee met at 09:01

CHAIR (Senator Askew): I declare open this meeting of the Senate Community Affairs Legislation Committee. The Senate has referred to the committee the particulars of proposed expenditure for 2019-20 and related documents for the Health portfolio and the Social Services portfolio, including Services Australia, formerly the Department of Human Services. The committee may also examine the annual reports of the departments and agencies appearing before it. The committee has set Thursday 31 October 2019 as the date by which senators are to submit written questions on notice, and has fixed Thursday 12 December 2019 as the date for the return of answers to questions taken on notice. Under standing order 26, the committee must take all evidence in public session. This includes answers to questions on notice.

Officers and senators are familiar with the rules of the Senate governing estimates hearings. If you need assistance, the secretariat has a copy of the rules. I draw the attention of witnesses to an order of the Senate on 13 May 2009 specifying the process by which a claim of public interest immunity should be raised and which I now incorporate in Hansard:

The extract read as follows—

Public interest immunity claims

That the Senate—

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

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

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

(1) If:

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

(b) an officer of the department or agency to whom the request is directed believes that it may not be in the public interest to disclose the information or document to the committee, the officer shall state to the committee the ground on which the officer believes that it may not be in the public interest to disclose the information or document to the committee, and specify the harm to the public interest that could result from the disclosure of the information or document.
(2) If, after receiving the officer’s statement under paragraph (1), the committee or the senator requests the officer to refer the question of the disclosure of the information or document to a responsible minister, the officer shall refer that question to the minister.

(3) If a minister, on a reference by an officer under paragraph (2), concludes that it would not be in the public interest to disclose the information or document to the committee, the minister shall provide to the committee a statement of the ground for that conclusion, specifying the harm to the public interest that could result from the disclosure of the information or document.

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

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

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

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

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

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

(13 May 2009 J.1941)
(Extract, Senate Standing Orders)

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

An officer called upon to answer a question should speak clearly into the microphone. Please make sure all mobile phones are switched off or turned to silent. I remind senators and witnesses that microphones remain live unless I instruct otherwise—for example, at suspension or adjournment. I would ask photographers and camera operators to follow the established media guidelines and the instructions of the committee secretariat. As set out in the guidelines, senators' and witnesses' laptops, mobiles, other devices and personal papers are not to be filmed or photographed.

Department of Health

[09:03]
CHAIR: The committee's proceedings today will examine the Health portfolio, beginning with the whole-of-portfolio and corporate matters. The hearing will then follow the order as set out in the circulated program. The committee's scheduled break times are listed in the program or as required. The committee will now begin consideration of the Health portfolio. I welcome the Minister for Aged Care and Senior Australians, Senator the Hon. Richard Colbeck, representing the Minister for Health. I also welcome the Secretary of the Department of Health, Glenys Beauchamp, and officers from the department. Minister or Secretary, would you like to make an opening statement?

Senator Colbeck: I don't have one.

Ms Beauchamp: I just wanted to draw to the committee's attention all of the work that we've done in response to Senator O'Neill. I think Senator O'Neill asked that we be ready to table a series of answers to questions. I can either flag that and do that now or within each of the outcomes.

Senator O'NEILL: If you could do that now, Ms Beauchamp, that would be fantastic. Thank you very much. Can I just check that, in line with the requests, all of the matters that were in my letter dated 1 October have actually been provided? Are there any gaps?

Ms Beauchamp: Could I just go through them?

Senator O'NEILL: Yes.

Ms Beauchamp: I think you've asked for an updated list of the Community Health and Hospital Program grants?

Senator O'NEILL: Yes.

Ms Beauchamp: We have broken that down into quite a detailed spreadsheet. We will table that today and I can do that now.

Senator O'NEILL: Thank you.

Ms Beauchamp: In terms of your second request, I think you also wanted an update of all of the Medical Research Future Fund grants?

Senator O'NEILL: Yes.

Ms Beauchamp: Certainly we will provide that and the 10-year plan and a breakdown between each of those key areas.

Senator O'NEILL: Thank you.

Ms Beauchamp: In terms of updated figures on how many people have opted out of My Health Record and what participation rate it represents, I've just got a summary to provide as well, and that is certainly in line with the public commentary and our previous questions on notice that, whilst the opt-out period has finished now, certainly over 90 per cent of people have a My Health Record now.

In terms of medical benefits, GP bulk-billing rates and specialist bulk-billing, we have provided a summary of each state and territory GP bulk-billing rates, the percentage of patients who have all GP services bulk-billed, the average out-of-pockets and the same for specialists. But what we haven't done—and I'll take this on notice—is provided it by electorate. That is the only piece of work that is outstanding in response to your letter.

Senator O'NEILL: Thank you. And 4.3?
Ms Beauchamp: We can certainly table that in terms of all the progress on the PBAC recommendations since 2013.

Senator O'NEILL: I want to express my thanks for the work that you did in providing that. Could I get an indication of when you might be completing the work by electorate?

Ms Beauchamp: It should be in the next few days.

Senator O'NEILL: Excellent. I notice you're going to provide me with a hard copy, but do you also have a soft copy you could provide?

Ms Beauchamp: I haven't personally got a soft copy. I've only got the big hard copies. They are very large spreadsheets.

Senator O'NEILL: They are. If you could forward that to my public address, senator.o'neill@aph.gov.au?

Ms Beauchamp: Through the committee secretary?

Senator O'NEILL: That is even better. Thank you very much.

Senator WATT: We have a couple of questions for cross-portfolio. Thanks again to you and your staff for appearing today. I just want to start with some matters about the cost of health care. We are asking that here because it involves obviously a range of different aspects of health care. Can you confirm that the quarterly Medicare statistics show that the average out-of-pocket fee to see a GP in 2018-19 was $37.53?

Senator O'NEILL: I might ask Ms Shakespeare to come to the table to answer the details on that.

Senator WATT: I'm happy to ask the question again once you get seated, Ms Shakespeare. So just to repeat, Ms Shakespeare, are you able to confirm that the quarterly Medicare statistics show that the average out-of-pocket fee to see a GP in 2018-19 was $37.53?

Ms Shakespeare: Sorry? What year?

Senator WATT: For 2018-19. Just so you've got the right figures there—what I'm asking is whether the quarterly Medicare statistics show that the average out-of-pocket fee to see a GP in 2018-19 was $37.53?

Ms Shakespeare: I'm afraid I don't have the quarterly statistics here. I have the annual statistics here. If you'd like the quarterly statistics, the officers for outcome 4 will be here later in the day.

Senator WATT: They are published statistics, in my understanding, the quarterly statistics?

Ms Shakespeare: Yes.

Senator WATT: Perhaps we could let you gather those while I hand over to someone else and maybe come back on that. Is that okay?

Ms Shakespeare: I can look at them on the website.

Senator WATT: Yes, that way we might be able to cover a couple of other things and then come back to this.
Ms Beauchamp: We also have the longitudinal information that we've just tabled in responding to Senator O'Neill's questions in terms of out-of-pockets since 2012-13.

Senator WATT: So, the table that's just been tabled has that information in it as well?

Ms Beauchamp: It has not the quarterly but the average over the year.

Senator WATT: Does the table that we've been given this morning also show that the average out-of-pocket fee to see a GP in 2018-19 was $37.53?

Ms Beauchamp: What we've tabled this morning shows $38.46.

Senator WATT: So, $38.46 was the average out-of-pocket fee to see a GP in 2018-19?

Ms Beauchamp: That's correct.

Senator WATT: I was going to say 'when is that up till'? That is a financial year?

Ms Beauchamp: That is actual year, in 2018-19.

Senator WATT: Does that table have previous years in it as well?

Ms Beauchamp: Yes, it does.

Senator WATT: Are you able to confirm that that is a record high for out-of-pocket fees to see a GP?

Ms Beauchamp: What do you mean by 'a record high'?

Senator WATT: Is that the highest that we have seen compared—

Ms Beauchamp: It has grown over the years, yes.

Senator WATT: That is the highest average out-of-pocket fee to see a GP ever?

Ms Beauchamp: In nominal rates, yes.

Senator O'NEILL: In nominal rates. What is that for ordinary Australians? Is it costing more? You say 'at a nominal rate'. For me, can I just say, it matters that we get on the record what it actually means for Australians in standard language that might be used at the coffee counter.

Ms Shakespeare: That's the out-of-pocket average for those people that do experience an out-of-pocket cost for seeing a GP. Some 86.2 per cent of GP services are bulk-billed, at no cost at all to the patient, which is also a record high. There are record high numbers of people not being charged, but where people are charged costs that's the average out-of-pocket cost.

Senator WATT: Does the table also give figures for out-of-pocket fees for specialists?

Ms Beauchamp: Yes, it does.

Senator WATT: What's the average out-of-pocket fee to see a specialist in 2018-19?

Ms Beauchamp: For 2018-19, $83.77. Again, in terms of a specialist attendance that's bulk-billed, it was also the highest in 2018-19, at 31.5 per cent.

Senator WATT: Thank you for that. I take on board what you're saying about access, but it is the case that the average out-of-pocket fee to see a specialist in 2018-19 was $83.77.

Ms Beauchamp: That's correct.

Senator WATT: Is that also a record high?

Ms Beauchamp: Yes, that's gone up but, similarly, those that are bulk-billed have also gone up as a record high.
Senator WATT: Do you have figures there about private health insurance premium increases?

Ms Shakespeare: The officers for outcome 4 will be here later today.

Senator WATT: We will get into detail then. But in terms of top line figures, are you able to confirm that private health insurance premiums have increased by an average of 30.01 per cent since 2014?

Ms Shakespeare: We will have to take that on notice. We do know that the premium increase that took effect on 1 April this year was 3.25 per cent, which is the lowest average premium increase in 18 years.

Senator WATT: Thank you. But what I'm asking about is the increase since 2014. So, you don't have any figures there, whether it be in the table or otherwise, that tell us that?

Ms Shakespeare: I don't think that was requested in the information we've just tabled. However, the officers for outcome 4 will be here later today and can provide that information when they are here.

Senator WATT: It is the case, though, that average private health insurance premiums are also at record highs? That is correct, isn't it?

Ms Shakespeare: The private health insurance premium increase this year was 3.25 per cent.

Senator WATT: That wasn't my question.

Ms Shakespeare: That is not a record high.

Senator WATT: That wasn't my question. It might be for the minister to advertise the government's achievements rather than public servants. My question was whether private health insurance premiums are higher now on average than they have been in the past?

Ms Shakespeare: In the past?

Senator WATT: Ever.

Senator DEAN SMITH: Chair, I think we are probably wandering out of the portfolio now. But if Senator Watt is persistent, I would like the department to put on the record what are the bulk-billing rates. You made a general statement, but I'd like some clarity around what are those bulk-billing rates.

Senator WATT: I'm happy for that, Senator Smith, but I might just try to get an answer to my question first, if that's okay. You have told us that premiums this year have increased by around three or so per cent on average.

Ms Shakespeare: So, 3.25 per cent on average.

Senator WATT: That's an increase on last year, where we saw an increase on the previous year, where we saw an increase on the previous year. So, it is the case that the average private health insurance premiums that we are seeing now are the highest that we have ever seen, because they have increased from year to year?

Ms Shakespeare: They do increase from year to year.

Senator WATT: So, they are the highest that we have seen on average?

Ms Shakespeare: On average, yes. The particular products, I couldn't say.
Senator WATT: Talking about out-of-pocket costs in general, are you able to confirm that the Australian Institute of Health and Welfare has found that Australians pay an average $1,578 per person in out-of-pocket costs each year?

Ms Beauchamp: Sorry. I haven't got that information in front of me. I'd have to confirm that with the officers.

Senator WATT: Is there anyone else at the table who has access to those figures?

Ms Shakespeare: There will be officers.

Senator WATT: I know we can deal with AIHW later. We are asking this here because out-of-pocket costs obviously cross a range of health activities. That's why we thought it was appropriate to deal with that in cross-portfolio. So, we don't know anything about what the AIHW has had to say about this?

Ms Shakespeare: There will be officers here during the day who are very familiar with the AIHW report and can provide information.

Senator WATT: In general terms, though, is it the case that the average out-of-pocket costs paid by Australians each year are higher now than they have been in the past?

Ms Shakespeare: I think that's probably a reasonable assumption, but it would be good to check that with the officers who are familiar with the contents of that report.

Senator WATT: So, it's a record high?

CHAIR: Senator Watt, I think we have answered that question. We might move on to the next one.

Senator WATT: So, it's a reasonable assumption that it's a record high for out-of-pocket costs. Finally, are you able to confirm—and I think this is a matter of public record—that the Australian Institute of Health and Welfare has also found that 1.3 million Australians a year delay or avoid Medicare services due to these costs? That's a fact, isn't it?

Ms Shakespeare: I think it would be best if the AIHW were asked about their methodology for estimating this.

Senator WATT: I'm happy to get into their methodology. All I'm seeking is confirmation of what they found to make sure that I've interpreted it correctly that 1.3 million Australians a year delay or avoid Medicare services due to out-of-pocket costs?

Ms Shakespeare: I think it would be best if the AIHW were asked about their methodology for estimating this.

Senator WATT: I'm happy to get into their methodology. All I'm seeking is confirmation of what they found to make sure that I've interpreted it correctly that 1.3 million Australians a year delay or avoid Medicare services due to out-of-pocket costs?

Senator Colbeck: Senator Watt, the officials have said they don't have the information in front of them.

Senator WATT: No, that's not what they said. Ms Beauchamp, can you confirm that basic fact?

Ms Beauchamp: I think that's something to confirm with the AIHW. I'm aware of what they have said. But as Ms Shakespeare said, I don't understand the methodology.

Senator WATT: I know. I'm very happy to ask them some detailed questions about methodology. I think you just said that—

Ms Beauchamp: I understand the AIHW has provided that figure, yes.

Senator WATT: The figure that they provided is that 1.3 million Australians a year delay or avoid Medicare services due to their out-of-pocket costs. That's what they have found?
Ms Beauchamp: I understand the AIHW have found that.

Senator O'NEILL: Is that correct?

Ms Beauchamp: I can't say whether it's correct or not. That is what the AIHW has determined.

Senator O'NEILL: Do you doubt the efficacy of what they do? Do you think they could be wrong, Ms Beauchamp? I think 1.3 million Australians know how much it costs them and that's why they're choosing not to go.

Ms Beauchamp: I think it's better understanding exactly what that means. I think the focus has been on out-of-pockets. We've also got record high bulk-billing rates. We have got much improved access.

Senator O'NEILL: Yes, but that doesn't help the people who haven't got the money to go and get the health services, does it? We need some straight answers. The reality is there are 1.3 million Australians who are not getting health services according to the AIHW, who will be here later to confirm. I'm sure they've told you about this, though. As the secretary of the department, I thought you would be very aware of it.

Ms Beauchamp: I don't know what year it applies to, for example.

Senator O'NEILL: Does it really matter? If 1.3 million Australians can't get it in any year, isn't that a problem?

Ms Beauchamp: I think that is a problem in terms of access. I think there has been much improvement around access for people accessing GPs and specialists over recent times.

Senator O'NEILL: Not for that 1.3 million who can't get the service because they can't afford it.

Ms Beauchamp: I'd like to confirm what year that is and whether that's the most up-to-date information.

Senator O'NEILL: I'm sure the people who couldn't get the service know what year it was. Thank you.

Senator DEAN SMITH: Just to put some of Senator Watt's questions in context, Ms Shakespeare, can you just share with the committee what are the latest figures around the GP non-referred bulk-billing rate?

Ms Beauchamp: The current bulk-billing rate for GP non-referred services is 86.2 per cent.

Senator DEAN SMITH: Is that a record high?

Ms Shakespeare: Yes.

Senator DEAN SMITH: What is the specialist attended bulk-billing rate?

Ms Shakespeare: It's 31.5 per cent.

Senator DEAN SMITH: Is that a record high?

Ms Shakespeare: It is.

Senator DEAN SMITH: Finally, what is the total Medicare bulk-billing rate?

Ms Shakespeare: It's 79.2 per cent.
Senator DEAN SMITH: So, on those three measurements, more Australians are getting medical treatment without having to reach into their pockets; is that a correct statement?

Ms Shakespeare: That's correct.

Senator DEAN SMITH: I turn to private health insurance matters, given that these were raised by Senator Watt as well. I've seen a statement that says—and I just want you to confirm that this is correct—that the coalition's reforms have delivered the lowest premium change in 18 years at 3.25 per cent, lower than every year under Labor and lower than the medical inflation rate of 4.2 per cent. Is that a correct statement?

Ms Shakespeare: Yes, the 3.25 per cent increase this year was the lowest for 18 years.

Senator O'NEILL: I have a couple of questions about the national action plans that I would like to ask. Do we have the right people at the table?

Ms Beauchamp: I think we are still doing cross-portfolio.

Senator O'NEILL: Yes, we are.

Ms Beauchamp: And we are then, I think, going on to aged care. But in terms of the action plans, they are under the preventive health outcome.

Senator O'NEILL: There are so many of these plans that have been launched. They go across all outcomes and programs.

Senator DEAN SMITH: This is a habit of yours, Senator O'Neill, to come to this committee and raise specific outcome matters in whole of portfolio. You've done it previous times. The chair is probably not aware of that, given that Senator Askew is relatively new. Chair, if I can just impress upon the committee that it is our long-established practice to go outcome by outcome, as the committee has previously agreed, and national action plans are not whole of portfolio.

Senator O'NEILL: Can I just say, Chair, if these are all about preventive health and they were only in that area then that would be appropriate, but these seem to range across a range of portfolio areas, which indicates to me that this is the best place to ask these questions.

Ms Beauchamp: I have the officers here for outcome 2, specifically to talk about the action plans and progress on those.

CHAIR: That was scheduled for 3.15 pm. We will be happy to look at that again then.

Senator WATT: Are you saying that they are here now?

Ms Beauchamp: No. I said I will have them here under outcome 2, which is scheduled for 3.15 pm, and specifically to look at the progress on the action plans.

CHAIR: The program has been circulated on that basis. That is why the representatives won't be here till then.

Senator O'NEILL: How many plans are there?

Ms Beauchamp: I'd have to take that on notice and wait for the officers to get here.

Senator O'NEILL: And you're confident, Ms Beauchamp, that they are all preventive?

Ms Beauchamp: They are all sitting, in terms of responsibility, under program 2.4, most of those.

Senator O'NEILL: Most or all?
Ms Beauchamp: From my understanding, most.

Senator O'NEILL: I don't want to get to 2.4, Chair, and find out there are items that are outside this that I can't ask about.

Ms Beauchamp: I'll make sure that we have all the offices here that are relevant for the action plans.

Senator O'NEILL: For all of the plans?

CHAIR: That is probably the best outcome.

Senator O'NEILL: All of the national action plans? I will be able to ask all of those questions?

Ms Beauchamp: Yes.

Senator WATT: Could I just ask a couple of follow-up questions on the matter that Senator Smith raised?

CHAIR: Okay.

Senator WATT: Of course, another way of looking at those figures is that it's just 66.3 per cent of patients who are always bulk-billed for GP services?

Ms Shakespeare: Yes, that's the rate of people who are bulk-billed for 100 per cent of their GP services.

Senator WATT: And the figures are even lower for specialists? Only 31.5 per cent of patients are always bulk-billed for specialists?

Ms Shakespeare: No, I think 31.5 per cent was the bulk-billing rate for specialist services.

Senator WATT: Meaning that 31.5 per cent of patients are always bulk-billed for specialists?

Ms Shakespeare: No, I'm not sure that I've got the figure for patients who are bulk-billed for 100 per cent of their specialist services.

Senator WATT: What that figure means is that 31.5 per cent of specialist services are bulk-billed?

Ms Shakespeare: Sorry. That's my mistake. It's 31.5 per cent who have all of their specialist attendances bulk-billed.

Senator WATT: And the remaining 68.5 per cent are paying the highest out-of-pocket costs we've seen for specialists?

Ms Shakespeare: The remaining patients may have had one service that was not bulk-billed during the year. They may have had more. It's hard to tell from averages.

Senator WATT: Yes. And on average the out-of-pocket costs for those other 68.5 per cent of patients are the highest we've seen?

Ms Shakespeare: Those average figures are as the Secretary went through before.

Senator WATT: Being the highest we've seen?

Ms Shakespeare: I can't remember the amount that was read out. It's in the table of figures—

Senator WATT: It was 83.77.
Ms Shakespeare: Yes.

Ms Beauchamp: That's been tabled.

Senator WATT: We're just having a look through the information that's been tabled.

Senator DEAN SMITH: Excuse me, Chair? Why has it been tabled for some senators and not all senators?

Senator WATT: Sorry. I thought it had been.

Senator DEAN SMITH: No.

Senator WATT: I may have misinterpreted an email that I've received. I'll check that.

CHAIR: Have you got that electronically?

Senator O'NEILL: No, we're still waiting for it electronically. There's only one copy.

Senator WATT: Let me just check whether I've misinterpreted this email.

CHAIR: Thank you.

Senator WATT: I can come back on that.

CHAIR: Are there any other questions for cross-portfolio?

Senator McCARTHY: Yes. I just want to go to staffing. According to the staffing of agencies document in the 2019-20 budget papers, there was a staffing reduction of 107 over the last financial year across health agencies. Are you able to comment on this, Ms Beauchamp?

Ms Beauchamp: I haven't got the detail in front of me, but they primarily relate to machinery-of-government changes for our portfolio. We had a number of staff go to the Department of Social Services around the administration of grants, for example, last year and it would also reflect some projects that may be terminating or finishing from year to year.

Senator McCARTHY: Would you know the list of those programs? Is that something you can provide to the committee?

Ms Beauchamp: I can certainly take that on notice, yes, but primarily it's the transfer of resources between agencies.

Senator McCARTHY: Are you able to provide comment on the Department of Health's reduction of 259 ASLs?

Ms Beauchamp: That primarily relates to my previous answer in terms of the administration of grants going to the Department of Social Services.

Senator McCARTHY: What was the department's expenditure on consultancy services year to date this financial year?

Ms Beauchamp: For the financial year 2018-19 we spent on consultancies $46.9 million.

Senator McCARTHY: What was the department's advertising and information campaigns expenditure in the current financial year?

Ms Beauchamp: In the current financial year? I'd have to ask Mr Yannopoulos.

Mr Yannopoulos: I will just find that data for you.

Ms Beauchamp: When you say the current financial year, this is 2019-20?

Senator McCARTHY: That's correct.
Mr Yannopoulos: I only know the budgeted figure for this year, which was $11.3 million. I don't have the year to date for this financial year with me.

Senator McCARTHY: Would you be able to take that—

Mr Yannopoulos: Yes, of course. Actually, sorry. The answer is zero; we've spent nothing on advertising campaigns so far this financial year.

Senator McCARTHY: Sorry? What did you say the total budget is?

Mr Yannopoulos: It's $11.3 million.

Senator McCARTHY: According to the 'Staffing of agencies' document, the Australian Institute for Health and Welfare staff levels have reduced by a little over three per cent, or 11 people, in the last financial year to comply with the 319 cap. The AIHW recently incorrectly reported that 2.1 million Australians had mental health treatment plans. The AIHW also recently incorrectly reported that the number of Australians with private health insurance had decreased by two million over a decade. Are you concerned this staffing cap and reduction in staffing numbers is impacting on the quality of data and research that's being provided?

Ms Beauchamp: The AIHW hasn't been called today. Whilst I cannot speak for them in detail, we have met with the AIHW. There were two incorrect figures announced, as you've mentioned, and they certainly weren't related to staff reductions. I think they were more just a misinterpretation of the figures and one was actually a typographical error.

Senator McCARTHY: But does it concern you that it is having a possible impact on the data research?

Ms Beauchamp: I don't think the staffing itself is having an impact. They're a highly skilled group and we're in the process of looking at, for example, sharing our graduate program with the AIHW so we can actually improve data analytics, research and the like between the department and the AIHW.

Senator McCARTHY: If you don't think the staffing numbers are impacting on the quality of data and research, what do you think it might be?

Ms Beauchamp: I think you would have to ask specifically the reason for those errors that occurred to the AIHW.

Senator O'NEILL: Could I just ask a couple of questions about the Independent Health Advice Panel.

Ms Beauchamp: That is more directed to the Home Affairs portfolio.

Senator WATT: Let's wait and see what the questions are.

Ms Beauchamp: But they've got responsibility for the panel.

CHAIR: Professor Murphy, are you able to answer some questions?

Prof. Murphy: I don't believe so. I'm appointed by parliament on that panel. It's administered by Home Affairs and my role on it is as a clinician along with several external clinicians. I don't think it's appropriate for the Department of Health to speak about the operations of a Home Affairs panel.

Senator O'NEILL: I'll ask you in your role as a panel member then, if I can, Professor Murphy, from your experience of it as the Chief Medical Officer, which gives you some significant role in this, I expect. How often does the panel meet?
Prof. Murphy: I think those questions should be directed to Home Affairs.

Senator O'NEILL: You may believe that, but I am asking you in your capacity as the Chief Medical Officer just to tell me the facts in your experience. They're not particularly onerous questions.

Prof. Murphy: No, they're not onerous questions.

Senator O'NEILL: You may believe that, but I am asking you in your capacity as the Chief Medical Officer just to tell me the facts in your experience. They're not particularly onerous questions.

Senator O'NEILL: Let's start with the easiest one. How often does the panel meet?

Senator Colbeck: Chair, it is administered in a different portfolio.

CHAIR: That's right.

Senator Colbeck: Questions such as this, which are clearly operational, should be—

Senator O'NEILL: Senator Colbeck, are you saying that you don't want the questions to be asked? Is this another part of the government's cover-up?

Senator Colbeck: I'm actually saying that they should be directed to the appropriate portfolio. I'm not saying that they shouldn't be asked.

Senator O'NEILL: The Chief Medical Officer attends the meetings. He's required to answer questions.

Senator Colbeck: Yes, but he doesn't have responsibility for the operation of the panel you are asking about.

Senator O'NEILL: I'm not trying to rewrite his role.

Senator WATT: If we have a chance to ask the questions, it is about Professor Murphy's—

Senator Colbeck: I'm happy to do that. I am genuinely happy to do that, but I don't think it's appropriate—and I'm just putting that on the record to start with—for the Chief Medical Officer—who is a member of the panel but doesn't have responsibility for the administration of the panel, which sits in another portfolio—to be asked questions that he won't clearly have information around because he doesn't have responsibility for administration. If he's unable to answer the questions, he should be allowed to actually say that and not be harangued.

Senator WATT: Sure. That's fine. The problem is that some of the questions that we have are specifically about Professor Murphy's involvement, his role, et cetera, and we can't ask Professor Murphy those questions in Home Affairs because he does not attend those estimates.

Senator Colbeck: I think that's reasonable, but I'm just putting on the record some of the operational things should be appropriately addressed to the portfolio where they are managed.

Senator O'NEILL: I think that's reasonable, but I'm just putting on the record some of the operational things should be appropriately addressed to the portfolio where they are managed.

Senator O'NEILL: Professor Murphy, how many meetings have you attended of the panel?

Prof. Murphy: I don't have that data in front of me, but except for periods when I've been on leave I've attended every meeting and the panel meets between one and three times a week. It meets as required. The panel is convened by Home Affairs when there are cases where the minister has refused transfer and we meet to consider those cases. We try to consider more than one case at a time because the panel is mainly volunteer doctors from externally. And it is to get people together for efficiency. I don't know exactly how many times I've attended, but we've considered over 100 cases.
Senator O'NEILL: It was established on 2 March?

Prof. Murphy: Again, I haven't got any of the administrative information in front of me, but that sounds about right.

Senator O'NEILL: Since that period of time, with 100 assessments you have met on average one to three times per week; is that correct?

Prof. Murphy: It varies. Yes, that's my recollection, but I do not have any data in front of me.

Senator O'NEILL: I'm happy for you to correct the record if need be after this, but thank you for your answer. Part of the role of the panel is to assess and report on the physical and mental health of transitory persons who are in regional processing countries and the standard of health services provided to them. Has the panel been on a tour of Manus Island or Nauru yet? Have you been on a tour?

Prof. Murphy: I have not personally been on a tour. Two members of the panel have visited the health facilities in Papua New Guinea.

Senator O'NEILL: Two members of the panel?

Prof. Murphy: Yes.

Ms Beauchamp: Can I just reiterate I think it's inappropriate for Professor Murphy to speak on behalf of the panel. He can speak about his involvement on a personal level, but in terms of the operation of the panel, and representing the views of the panel, I think that is best directed to Home Affairs.

Senator O'NEILL: You have not been. Do you have plans to go either to Manus Island or Nauru?

Prof. Murphy: Not personally. I'm not planning on going at the moment, no.

Senator O'NEILL: Not at the moment?

Prof. Murphy: There are no plans for me to go. The panel has taken the view that visits to these facilities are best taken by the independent non-government medical representatives, because they are fully independent of government.

Senator O'NEILL: So, at this stage, no plan for you to go—

Prof. Murphy: No.

Senator O'NEILL:—because of that reason? Are you seen as too close to the government?

Prof. Murphy: No, not necessarily that. We have to prioritise who would go. It is obviously very sensitive and tricky to send large groups of people to these facilities, and we wanted to make sure that the panel members were, firstly, independent of government and, secondly, had the right clinical background to make the best assessment of the health services, and that was the basis upon which panel members were chosen to go.

Senator O'NEILL: Thank you for your answer. I understand that 23 people have been transferred via the medevac laws after being initially refused by the minister?

Prof. Murphy: I can't comment on the specifics.

Senator Colbeck: That is clearly a matter for the Department of Home Affairs.
Senator O'NEILL: Could I ask you about your decision-making in that body around those 23 people being transferred?

Prof. Murphy: It really does go to the operation of the panel. My role in that panel is as one of a number of clinicians who have in every case reached a consensus decision.

Senator O'NEILL: You're telling me that every decision has been unanimous; there has been no dissent?

Prof. Murphy: There's often been discussion. I haven't been involved in every meeting, because I've been on leave for some period. But every meeting that I've been involved in the panel has reached a consensus decision. There may have been considerable discussion, but that's been the outcome.

Senator O'NEILL: Thank you very much. Could you, in your personal experience, not speaking for the panel, describe to me the process of what happens when a submission comes before you?

Prof. Murphy: Again, that does speak to the operation of the panel. I really can't see why these questions can't be directed to Home Affairs.

Senator O'NEILL: I'm asking you about your experience of this process.

Prof. Murphy: But my experience of this process is no different from any other panel members. We all get the same briefings, the same information and have the same process. I'm just treated as one member of a panel in no different way to anybody else.

Senator O'NEILL: Thank you. That's quite helpful. What does a briefing document look like for these matters?

Prof. Murphy: There's a considerable number of briefing documents that we are presented with. We are given a large body of information and, again, the details of that you'd have to get from Home Affairs. But we are given a very substantial portfolio of information on which to make our decision.

Senator O'NEILL: You have never felt in this process that there was inadequate information or a lack of professional care in the preparation of documents for your consideration?

Prof. Murphy: I haven't made a judgement on that matter. I think we have always looked at the quality of the information we get. Sometimes the referring doctor's information is incomplete. Sometimes medical records might be incomplete. But we have had a very substantial portfolio of information, and we look at the totality of that information in making our decisions.

Senator O'NEILL: Given that you said that sometimes you feel it's a little incomplete, do you request further information?

Prof. Murphy: We have done so on a number of occasions.

Senator O'NEILL: To make sure that you're able to make a fully informed, professional judgement?

Prof. Murphy: To the best that one can without actually being involved in a clinical consultation, yes.
CHAIR: Senator O'Neill, I would like to go to Senator Roberts, who has come in and needed to ask a question on this section as well.

Senator ROBERTS: I'm not sure that this is the right place. Firstly, thank you for coming. I'd like to ask questions about reducing the gap in information between hospital doctors who have done a procedure/operation and GPs. Would that be under primary healthcare, quality and coordination?

Ms Beauchamp: What sort of question are you asking?

Senator ROBERTS: Investments in systems to enable secure patient information sharing is very common, yet in Australia only about 20 per cent of GPs, I think according to an AMA study, say they receive data back from hospitals after a patient emergency admission. That's one of the questions. I just want to discuss that.

Ms Beauchamp: I think that is more appropriate under outcome 1. Outcome one is scheduled for— I'm just looking at what program—12.30 pm, yes.

Senator ROBERTS: Thank you very much. Thanks, Chair.

Senator GREEN: Can I ask some questions on the youth portfolio during this whole-of-portfolio section? I've had a look at the program and there doesn't appear to be a time allocated to the line for youth, so this is probably the best place to ask it.

Ms Beauchamp: Obviously youth is very much a whole-of-portfolio issue.

Senator GREEN: Great.

Ms Beauchamp: We've got a dedicated team of officers on youth matters, particularly to support Minister Colbeck and coordination. Those officers will be available this afternoon as well under outcome 2, but if there's something that I could specifically answer—

Senator GREEN: Can I ask some questions on the youth portfolio during this whole-of-portfolio section? I've had a look at the program and there doesn't appear to be a time allocated to the line for youth, so this is probably the best place to ask it.

Senator GREEN: But there's no specific line item for youth under the budget?

Ms Beauchamp: That's correct.

Senator Colbeck: Bearing in mind that this portfolio came into being post the budget, which was brought down prior to the election.

Senator GREEN: How many speeches have you given as Minister for Youth, Minister Colbeck, and how many of those speeches have been to an audience of young people? That's people 24 and younger.
Senator Colbeck: I'm not sure that I've actually addressed specific forums. I've had quite a few meetings with youth organisations and groups and meetings with young people. I'd have to take that on notice. I'll have to go back through my diary and check it.

Senator GREEN: You're not sure if you've given any speeches about youth?

Senator Colbeck: If I want to give you a correct answer, I'll need to go back through my diary and check it.

Senator GREEN: Do you have any plans to make any speeches? Or do you need to check your diary for that one as well? Are there any big events coming up that you are planning on talking at?

Senator Colbeck: Again, I will have to check my diary and see what is ahead of me.

Senator GREEN: Have you met with any counterparts from state and territories, that is, the youth ministers from any states and territories?

Senator Colbeck: Again, I will have to check my diary.

Senator GREEN: What are your plans to help meet the needs and concerns of young Australians?

Senator Colbeck: The first thing that we've done as an agency is to work across government to find out where elements that specifically relate to youth have sat. Ms Beauchamp can probably give some details of the work that she has been doing on this portfolio's behalf to gather those things together. We've set up a group within this agency to oversee all of those things. We have established a youth task force which is currently out conducting a first round of consultations with youth organisations and organisations that provide services to young people around Australia. That will be followed up by a further round I will be engaged with as well. The initial process for us has been to gather together elements that directly relate to/impact on youth across government and pull those together. Those are now managed under this portfolio and then followed up by a number of consultations as we've indicated through the development of the youth task force.

Senator GREEN: Surveys and polls show that climate change and jobs are two of the biggest issues of concern for young people. Do you think that Australians are entitled to be concerned about climate change and this government's policies on climate change, or lack thereof, or should they just take a Bex and lie down, as the Prime Minister recommended?

Senator Colbeck: I don't dictate to anyone what they can and can't be concerned about. Climate change is one of the issues that's been raised with me as I've spoken to youth groups and young people around Australia. But the dominant issues that have come to me as I've spoken to young people around Australia relate probably to three key items, bearing in mind there is a range of items that they talk about. The key items that young people have spoken to me about so far would be mental health, employment and education and access to services in those spaces. But there are some youth groups who have come to me and some communications that I've had that relate to a range of things, and climate change is one of those.

Senator GREEN: I've got two more questions. I will whip through them.

CHAIR: Very quickly. We have someone waiting online to join us.
Senator GREEN: No problem. Does the government have any plans to combat the 11.7 per cent youth unemployment rate and the 18.7 per cent youth underemployment rate in Australia? I'm not referring to any plans that involve cutting penalty rates or that include the youth labour PaTH program.

Senator Colbeck: Firstly, I would reject the assertion in your question about the government cutting penalty rates. That has not occurred. That hasn't been an action of government. In fact, that was an action of the Fair Work Commission, which was established under a previous Labor government and basically—

Senator O’NEILL: Senator—

Senator Colbeck: Senator, you can ask your questions. I get to answer the questions. Thank you. It was established under the Labor government and mostly filled with Labor appointments. I will reject your assertion in relation to that straightaway. While we acknowledge that youth unemployment rates are too high, the core elements in addressing that are ensuring there are opportunities for economic growth. The fundamental thing that we will do, including a range of programs—and you have mentioned one of them, which is the PaTH program. There is also the Welfare to Work program that is in place. Speaking to young people as I did as recently as last week, they found that to be a fantastic program to give them opportunities to break particularly unfortunate cycles they were in and to get back on track.

As to ensuring there is the opportunity for jobs growth, I think the government can be very proud of its achievement in assisting business in the economy to create jobs since 2013. That is over 1.4 million jobs, with 100,000 of those being for young people. Maintaining good economic management; maintaining control of the budget will all be elements in making sure that young people have the opportunity to get jobs, and we will continue to get things like free trade agreements, which will provide additional business opportunities for people in the economy to grow jobs opportunities. And of course then there is the work that we're doing in the Employment Portfolio, which you are quite welcome to ask Senator Cash about, and the work that we are doing to increase opportunities for young people to get into apprenticeships, for example. All of those things flow into the work that we're doing to assist young people to get jobs.

Senator GREEN: Minister, are you seriously trying to say to young people across the country that your plan for young people is trade agreements and keeping the budget—

Senator Colbeck: No. I think you are selectively quoting my answer. I talked about the whole economy being strong, the continued jobs growth that we have had through the economy—

Senator GREEN: I'm talking about specific programs for young people.

Senator Colbeck: For businesses to create jobs—

Senator GREEN: I think the answer is that you don't have any specific programs for young people.

Senator Colbeck: You can try and verbal me all you like, but clearly the Labor Party doesn't understand the importance of a strong economy, which is what creates jobs.

Senator GREEN: Clearly you don't understand young people. That is fine. Thank you.
Senator Colbeck: I think that's an absurd statement. The Labor Party has no understanding of how the economy creates jobs, as demonstrated at the recent election with the imposition of $387 billion of new taxes and no funding for any of the programs or things that you are talking about.

[09:53]

CHAIR: I think we will end the discussion on whole-of-portfolio matters. We have Mr Callaghan from the Aged Care Financing Authority joining us shortly by phone. We will now move on to outcome 6, Ageing and aged care. Mr Callaghan, thank you very much for taking the time to join us this morning. I understand that Senator Griff has some questions as well. We might start anybody who has questions for Mr Callaghan, because we are very conscious that you have a limited amount of time.

Senator WATT: We are happy to bring forward our questions that we had for the financing authority. I mainly want to discuss some aspects of the Aged Care Financing Authority's annual report on the funding and financing of the aged-care industry in 2019. I'm assuming you've got some familiarity with that report?

Mr Callaghan: Yes, I have some.

Senator WATT: I was particularly interested in one sentence in your executive summary. I don't know whether you've copies there.

Mr Callaghan: I have a copy in front of me. This is the overview, is it?

Senator WATT: Yes, the executive summary. It's page xii. For the benefit of committees, we are getting copies of this run off.

Mr Callaghan: This is the last page of the overview?

Senator WATT: It's in the executive summary. Is that different to the overview? Let me see.

Mr Callaghan: Yes, I've got the executive summary.

Senator WATT: It's the seventh report on the funding and financing of the aged-care industry, July 2019?

Mr Callaghan: Yes, page 12.

Senator WATT: You will see right at the bottom of that page there's a sentence that reads, 'Changes to the Aged Care Funding Instrument (ACFI)—'

Mr Callaghan: Sorry. I'm not on the same page as you. I have the printed copy of it. Page xii is the very last page and it has a heading 'Sound management and governance arrangements'.

Senator WATT: Sorry. It's a little bit hard to hear you. Can you just say that again?

Mr Callaghan: On my copy, the printed copy of it, in the executive summary page xii is the very last page of it. It's just a short page, and the bottom section is 'Sound management and governance arrangements'.

Senator WATT: Are you looking at the July 2019 report?

Mr Callaghan: I'm looking at the July 2019 report, the printed copy

Senator WATT: I have a printed copy of that as well.
Mr Callaghan: What's the heading that you are referring to?

Senator WATT: The heading is 'Residential care'.

Mr Callaghan: For me that is page 10, on my copy.

Senator WATT: Maybe you don't have the cover pages or something. But, anyway, can you see the sixth paragraph under 'Residential care'?

Mr Callaghan: Starting 'Changes to the Aged Care Funding Instrument'?

Senator WATT: That's the one. That sentence reads:

Changes to the Aged Care Funding Instrument (ACFI) and the indexation pause impacted on the financial results of residential aged care providers in 2017-18. What do you mean by that?

Mr Callaghan: It's elaborated within the report that because ACFI contributes over 60 per cent of the revenue of residential aged-care providers, if there's a pause in the indexation—so the amount that ACFI is getting isn't rising with any rise in costs—and there was also a change in the scoring arrangement for one of the complex health cares. That meant that the amount of money they were getting for residents with complex healthcare for 2017-18 impacted on the revenue of residential aged-care providers. If costs were continuing to go up, then of course the financial performance was impacted. That was quite evident when you look at the overall financial performance of aged-care providers in 2017-18. There is quite a bit in the report that outlines this.

Senator WATT: When you refer there to 'changes to the Aged Care Funding Instrument', are you talking there about the $1.2 billion cut to the ACFI made in the 2016 budget?

Mr Callaghan: I'm specifically referring to the pause in indexation and the change in the scoring arrangements.

Senator WATT: Let's just take them separately. What that sentence says is that changes to the Aged Care Funding Instrument and the indexation pause impacted on the financial results. I'm assuming that each of them had an impact?

Mr Callaghan: Together they had an impact on it.

Senator WATT: When you talk about the changes to the Aged Care Funding Instrument, you are talking there about the $1.2 billion that was removed from the ACFI in the 2016 budget?

Mr Callaghan: As I said, I'm specifically referring to the pause in indexation and the change in the scoring arrangements.

Senator WATT: No, I'm not talking about what the impact is at this point. I will get to that.

Mr Callaghan: I can only say what I'm talking about, and that reference is referring specifically to the pause in indexation and the change in the scoring arrangements.

Senator WATT: What you mean by 'changes to the Aged Care Funding Instrument'?

Mr Callaghan: Back in 2017, they changed the scoring for complex health care so that when a resident came in there was a reduction in what it would take for them to be registered as high, high, high in the scoring of complex health care. That determined the amount of ACFI that the residential provider would receive. Also, a significant impact was that ACFI
did not rise; there was no indexation of ACFI in 2017-18. That's what I'm referring to in that sentence.

Senator WATT: I understand what you're saying about the scoring process. Is it your agency's view that the removal of the $1.2 billion in the ACFI impacted on the financial results of residential aged-care providers?

Mr Callaghan: Well, again, of course these changes had an impact on the revenue that the residential aged-care providers would be receiving, and that had an impact on their financial performance.

Senator WATT: I think you said that of course the removal of that funding from the ACFI had an impact on their revenue and impacted on their financial results; is that correct?

Mr Callaghan: Their ACFI did not go up in line with a rise in indexation, yes.

Senator WATT: What impact did the removal of that $1.2 billion dollars from the ACFI in 2016 have then on the capacity of the sector to provide services to residents?

Mr Callaghan: That's an area that you could say can be debated. In essence, if the reason that the government said that they changed the pause in indexation/changed the scoring was because—and this is all outlined in our update on the financial performance of aged-care providers that we released in 2018, which traces this through. If you look for the reasons for the change, if as the government said it was that the claiming behaviour of providers was growing faster than the acuity level of the population; if that was the case there would not be a significant impact. If it was the case that this was impacting on the ability of providers to be able to provide, if their cost base was continuing to rise such that they couldn't provide the same level of care, yes, there would be an impact. But it all goes back to determining what was the reason for the change in the ACFI and the pause in indexation. As I say, the government said that what they were seeing—and certainly the evidence seems to be there—was that ACFI was growing much faster than certainly the indexation rate, what you would expect would be growth in the acuity level, the frailty of the population, coming in. They were saying that there was some problem in the ACFI claiming. As I say, it's not straightforward to say this is what the impact was going to be. It comes back to deciding what was the reason for the change.

Senator WATT: Just to break that down, what you've said—and correct me if I get this wrong—about the removal of that $1.2 billion in 2016 from the ACFI is: 'of course it would have had an impact on the revenue and financial results of residential aged-care providers'.

Mr Callaghan: Yes.

Senator WATT: Then when we are thinking about the impact that has on services, it sounds like it depends a bit on the mix of residents and the level of acuity. Is that right?

Mr Callaghan: Yes. As I say, I think you would have to go back and look at why the change was made. What the government said at the time was that the rise in ACFI was growing faster than what they expected was the growth in acuity level or frailty. They said it was reflecting the claiming behaviour of providers. Providers, in terms of what they were doing, were getting extra ACFI payments that the government was saying didn't translate into the growth in the demand or the frailty of the residents coming in.
Senator WATT: I think when you answered the question about services initially you sort of said, 'If particular service providers did this, that would have an impact. If on the other hand they did this it would have an impact.' I take it that for some providers, depending on the level of care required by residents and other factors, the reduction in the ACFI funding in 2016 would have had to have had an impact on the services they provided, depending on the mix of patients and that kind of thing?

Mr Callaghan: I can refer you back to the reports that went out in 2018, including the report on an update on the financial performance of residential providers. In that report, I had a series of consultations with aged-care providers. The feedback from some providers in terms of their response to the changes in ACFI was along the lines of saying, if there was a problem in the claiming behaviour of some providers, they were using the system to maximise ACFI claims which perhaps weren't in line with the needs of the residents or excessive to the needs of the residents, then the government should have targeted those explicitly. It was a blunt instrument that they used across everyone. Effectively they are saying that their capacity to deliver the services was being impacted. There is a range of claims that providers have made. Some would say they have always been ethical providers, that there was no change in their claiming behaviour, and they felt that they were unjustifiably impacted by the change in ACFI and someone else was doing it. Where truth lies in all of that, I don't know.

Senator WATT: But you can't seriously be saying that a $1.2 billion cut to the ACFI hasn't had any impact on services across the board?

Mr Callaghan: As I explained, if you go back to saying, 'Why did the government do it?,' if it was that the growth was reflecting claiming behaviour and not the growth in acuity, if that was absolutely the case for all providers then, no, it shouldn't have had an impact on services; it was reflecting claiming behaviour. That's what the government said. I can only report that I spoke to a cross-section of providers who say that their claiming behaviour was correct. I should just note that there are lots of problems in the ACFI funding model. It has many, many deficiencies that may not reflect very well on what actually is the care requirements of the residents. This is why there have been trials to replace it. It has many deficiencies in terms of the capacity to ensure the funding is going to meet the needs of the residents. There are fundamental problems in the ACFI to start with that you have to take into account.

How could you make a claim that changing the pause in indexation had no impact on the care being provided to the residents? I have to keep coming back to saying, 'Why did the government do it? Can you look at the evidence to say, where did it transpire? All I can report on is the feedback I've got from consultations with providers.

Senator WATT: As to this feedback you've had from providers, it sounds like largely they have been people who have been claiming properly; they haven't been doing the wrong thing? Is that right?

Mr Callaghan: Every provider I spoke to said they were claiming properly, and someone else was the problem and they should be targeted, not the provider.

Senator WATT: That sounds like a familiar argument.

Senator DEAN SMITH: That is what they would have said in 2012-13 when the Labor government also tightened the compliance arrangements.
Senator WATT: You guys are just never going to work out that you have been in government for six years.

Senator Colbeck: We will remember history, but we will also remember when, as we've just been hearing, we reacted to what we saw as a problem, just as you did in 2012-13, and we are now moving towards the implementation of a new funding model. As we just heard, and as we believe, the ACFI instrument is no longer fit for purpose.

Senator WATT: Let's go back to Mr Callaghan. From the consultation you've undertaken with providers, who say that they have been claiming properly, have any of them reported to you that the cuts to the ACFI funding have meant there's been some impact on the services they have provided to residents?

Mr Callaghan: In the consultations I had with them, I was trying to ask what they were doing in response to the impact on their revenue. They said that they were looking at their costs, absolutely, and trying to improve their efficiency. Most said that they were looking at ancillary costs and it was impacting on some others. They were looking to improve their procurement arrangements, et cetera. They were moving into the losses. Certainly the priority was not to reduce the care component of that. They also noted there were many other impacts on their cost pressures that they were having to deal with which were causing concerns for them. It's a combination of the rising costs and whether the funding arrangements were in line with the extra costs that they were having to deal with, and some of those rising costs coming through with living wage costs. They were focused on the increased costs associated with quality. The feedback was that certainly the natural response, if you're looking at it and if you do see that your revenue is not growing as it was in the past, is to look at your cost base. A lot of it was trying to protect the level of quality and care that they were providing and looking at other means to reduce the costs.

Senator WATT: So the providers were telling you that, as a result of the cuts to the ACFI funding, they were having to try to trim some of their costs, and that partly related to what you called ancillary services. Is that things like catering, cleaning—those types of things?

Mr Callaghan: The things that they used to say were bits like pastoral care that they were doing. Some of it was impacting on the other activities they were providing. And, again, looking at trying to improve the efficiency, there were some who were outsourcing their provision of services and some were taking the opposite arrangement and looking to insource them. It was a range of areas to keep an eye on their cost base. But certainly, as we have seen, there is significant financial pressure in that those costs continue to be rising higher than their overall rise in the revenue even after we have seen the growth in indexation of ACFI. The pause has ended in the indexation; ACFI is going back up again.

Senator WATT: There are reports from Stuart Brown. I don't think the agency commissioned those. Are you aware of those reports?

Mr Callaghan: These are their regular survey reports they put out?

Senator WATT: Yes.

Mr Callaghan: Yes.

Senator WATT: There are two reports they have published in March and June 2019. Both have highlighted that the current funding model remains under significant strain. The June 2019 report makes this point quite categorically. The report states that the financial...
performance of the aged-care sector and specifically the residential care segment continues to be a significant concern. It states further that the residential care operating results for financial year 2019 declined in real terms even after the $320 million subsidy injection for the last quarter. That was the government's funding injection that they are referring to there. Does the Aged Care Financing Authority have any concerns about the viability of the aged-care sector given the views that have been expressed in these Stuart Brown reports?

Mr Callaghan: I would refer you to our report. Our report covers the financial returns of nearly all the sector—about 100 per cent coverage. What Stuart Brown provides is sort of an advanced survey covering about 40 per cent and it's only at facilities with your providers. If you have a look in our report and the one you referred to in July 2019, it has the full results for both home care and residential providers in 2017-18. It shows that there has been an overall decline in the financial performance of residential aged-care providers. We do go on, if you have a look there, and talk about—and this is what the Aged Care Financing Authority is meant to do—the implications of this for the viability and sustainability of the aged-care sector. We have a chapter near the end there that says if you have a look at the financial performance and the challenges—and this is elaborated even more in our submission to the royal commission—there are many hurdles that the sector has to confront now towards achieving the objective of a sustainable residential aged-care sector. Then we go on and elaborate a number of the characteristics that are required to achieve a viable and sustainable aged-care sector, taking on board the hurdles that currently exist. They extend beyond just financing as such and many of the other issues that are required to achieve a more sustainable aged-care sector. That is the bread and butter of what the Aged Care Financing Authority is for.

Senator WATT: I haven't had an opportunity to review your report in full. Listening to what you are saying there, does that mean that, given the hurdles that exist, the Aged Care Financing Authority does have concerns about the viability of the aged-care sector?

Mr Callaghan: The same hurdles would have existed before we saw the decline in the performance of the residential providers in 2017-18. Yes, there are many issues that need to be addressed to ensure the viability and sustainability of the residential aged-care sector. It's not simply money, it's getting the incentives right and getting the whole arrangements right. It's getting the roles and the competitive pressures right. It's improving the overall performance of the residential aged-care providers.

Senator WATT: Can I just get a direct answer, then? Does the Aged Care Financing Authority have any concerns about the viability of the aged-care sector given all of these factors?

Mr Callaghan: Yes.

Senator WATT: Thank you.

Mr Callaghan: It's clear in our report.

Senator DEAN SMITH: I have a question for the Secretary. It does relate to what we are talking about here. Senator Watt characterises the ACFI issue as a cut. But am I correct that it is better or more accurately described as a tightening of the ACFI assessment criteria? Is that a more accurate way to describe what was actually happening at that particular point in time?
**Ms Beauchamp:** That is correct. In terms of looking at the bottom line, the average government contribution through the ACFI instrument has actually gone up every year since 2012-13. So, not only has the funding per patient or care recipient gone up, the bottom line in terms of funding for residential aged-care facilities has also gone up over that period.

**Senator DEAN SMITH:** I think there is a table on page 12 of the financing agency's report that makes it very clear what the Commonwealth's contribution to residential aged care is. It shows it has actually been increasing. I think it is on page 12. Senator Watt will see that when he reads the full report.

**Ms Beauchamp:** That is correct.

**Senator Colbeck:** It is even in a bar chart to make it easy to read.

**Senator DEAN SMITH:** I have one other question. It was an interjection, but let's get it on the record. The tightening of the ACFI assessment criteria is not a new feature, is it, Secretary?

**Ms Beauchamp:** No, it's not.

**Senator DEAN SMITH:** When was the last time it was used? Or can you cite a previous time it has been exercised? 2012-2013?

**Ms Beauchamp:** It was 2011-12.

**Senator DEAN SMITH:** A cut, to quote Senator Watt.

**Senator Colbeck:** It was $1.6 billion in 2012.

**CHAIR:** Are there no further questions for Mr Callaghan around the table? Thank you very much for joining us by teleconference, Mr Callaghan. We will let you go as we are aware you have other commitments today. We will continue on with our outcome 6 discussions.

**Senator McCARTHY:** Can the department confirm how many residential aged-care facilities have been in contact with it in relation to their viability as required?

**Mr Hallinan:** We don't hold specific data on the number of providers that have contacted us.

**Senator McCARTHY:** Sorry, Mr Hallinan. I don't know if I am having hearing problems. I just can't seem to hear you very well.

**Mr Hallinan:** Sorry. No, we don't hold data on the number of providers that have contacted us about their finances.

**Senator McCARTHY:** You don't have the numbers?

**Mr Hallinan:** Not specifically, no.

**Senator McCARTHY:** Why don't you have the numbers?

**Mr Hallinan:** It's not something that we collect. It's not a regular occurrence for us.

**Senator McCARTHY:** Are you able to get the numbers?

**Ms Beauchamp:** For each and every service provider, of course we have very close working relationships with all of the peaks who represent the residential aged-care providers. As Mike Callaghan has referred to, there are a number of surveys that are undertaken through...
Stuart Brown and indeed the financing authority. We are in regular contact with the peaks around the health of the residential aged-care sector.

Senator McCARTHY: But isn't it a requirement under the Aged Care Act?

Mr Hallinan: They provide us their financial statements at the end of every financial year, but that's quite different to a contact with us to say that they are concerned about their finances.

Senator McCARTHY: So you can't provide figures then for 2015-16, 2016-17, 2017-18 and 2018-19 in relation to the question I have asked?

Ms Beauchamp: In terms of the number of contacts we have with individual service providers, I think that would be very hard to gather that information, particularly over past years in terms of every officer who's had a contact with a service provider around viability in particular.

Senator McCARTHY: You say it would be very hard, but are you able to do it?

Ms Beauchamp: I don't think so, without going through people's diaries and also confirming that with each and every service. I just think that would be something that's unreasonable to expect.

Senator WATT: But there are instances where service providers have contacted the department expressing concern about their viability?

Ms Beauchamp: Yes.

Senator McCARTHY: Are you able to give us information on those?

Senator WATT: How regularly do they happen?

Ms Beauchamp: We primarily deal through the peaks representing service providers and of course they have made much contact and lots of public statements. But in terms of actual individual service providers, I'd have to take that on notice to see what we can actually produce for you.

Senator McCARTHY: If you can take it on notice, that would be good. What support is the department offering the New South Wales Murchison Community Care 40-bed DP Jones Nursing Home, given it has gone into voluntary administration?

Mr Murray: The department has been involved with the Murchison facility since they contacted us and raised concerns about their future operations.

Senator McCARTHY: When was that, Mr Murray?

Mr Murray: I may have to take that on notice, but it's certainly over the past month in particular we have been in contact with the home and been involved in their discussion.

Senator McCARTHY: I missed that? Over the past?

Mr Murray: Certainly over the past month we have been in fairly regular contact with the provider as they have worked out the future for the business.

Senator McCARTHY: Does this include financial support?

Mr Murray: The department doesn't have the capability to provide individual financial support for businesses. We provide general subsidies as part of normal arrangements with funding providers, but there is not money available for specific services and specific issues.
The management of the viability of the service is ultimately an issue for the management and for them to determine the best path for that facility moving forward.

Senator McCARTHY: But there has been a conversation around it?

Mr Murray: There has been a conversation, yes.

Senator McCARTHY: What has been your advice to them? The provider in question, as I understand it, sought their own independent financial advice, which is the appropriate thing to do, on what the future for the business would be. What contingency plan has the department developed if there are more rural, regional or remote facilities that become unviable?

Mr Murray: As we have done in Murchison, we are always in contact with the provider if there are issues raised with us and we always make sure that the residents are looked after first and foremost. There is a clear plan we would always instigate in terms of ensuring that resident care continues. If a facility is to close, we assist the provider in looking for places where residents could be relocated if that becomes necessary. It may also be that other providers could be found who may be willing to take over services. We would assist and facilitate that process as well.

Senator McCARTHY: Can the department confirm what indicators were used to calculate the $320 million which should be allocated to residential aged-care facilities as part of the announcement made by the Prime Minister in February this year?

Mr Murray: That was ultimately a decision for government as to what it determined was the appropriate sort of funding amount to assist the sector.

Senator McCARTHY: So you're saying that it's up to the government to provide the indicators?

Mr Murray: It's up to the government to make the decisions as to the level of financial increase to the subsidies that are provided.

Senator McCARTHY: Yes, but the government is advised by the department. Have you made any recommendations in relation to that?

Mr Hallinan: We provided advice in a deliberative process of government.

Senator McCARTHY: Minister, can I ask you about the indicators?

Senator Colbeck: It was a decision of government at the time made by the Cabinet at that point in time.

Senator McCARTHY: So, what are the indicators?

Senator Colbeck: That would go to the advice that was provided by the department. Obviously, given it was a process of cabinet, that remains a cabinet-in-confidence process.

Senator McCARTHY: So we don't know what the indicators are?

Senator Colbeck: I have given you my answer to the question.

Senator McCARTHY: So, $320 million is to be allocated to residential aged-care facilities, and yet we do not know what indicators are being used to calculate that?

Senator Colbeck: As I said, it was a decision of cabinet at the time based on some advice provided, obviously. That was the outcome of the process that cabinet undertook at the time.
Ms Beauchamp: Whilst it was obviously a decision for government through the deliberative processes, it wasn't the only measure to support residential aged-care facilities announced at the time. There was a number of other measures in terms of assisting with business advice to the operators of residential aged-care facilities as well. There were a number of other measures and I think Mr Smith can probably elaborate on those.

Mr Smith: In addition to the $320 million injection there was also an increase to the viability supplement of 30 per cent which is paid to providers in rural, regional and remote areas as well as to providers who support homeless people and people from Aboriginal and Torres Strait Islander backgrounds. There was also a 30 per cent increase to the homelessness supplement at the same time, which supports providers who predominantly look after people with a homeless background or who are risk of homelessness. In addition to that, the government has announced the establishment of a business advisory service. Mr Murray can speak in more depth about that, but that's about providing support to services, home care and residential providers who are experiencing financial difficulty to support them to do the sorts of things Mr Callaghan was speaking about, how they can improve their operations and their efficiency to put themselves on a better viability footing.

Senator McCARTHY: So let me get those figures. Of the $320 million, a 30 per cent increase in relation to viability; is that correct?

Mr Smith: A 30 per cent increase to the viability supplement, yes.

Senator McCARTHY: You said 30 per cent in relation to homelessness?

Mr Smith: The homelessness supplement, yes.

Mr Hallinan: They are both in addition to the $320 million.

Senator McCARTHY: So, in addition to the $320 million?

Mr Hallinan: There is an ongoing uplift in the viability supplements.

Senator McCARTHY: How much of the $320 million has been allocated to date?

Mr Smith: It's all been paid out.

Senator McCARTHY: How was it decided which residential aged-care facility received funding first?

Mr Smith: It was paid via a general uplift to the subsidy. It was paid to all residential providers proportionally.

Senator McCARTHY: How many is that?

Mr Smith: There are 800-odd residential providers and 2,700 services. They all received an uplift.

Ms Beauchamp: In addition to those viability supplements, which are particularly focused on rural, regional and Aboriginal and Torres Strait Islander facilities, there was extra targeting for those services as well as the additional uplift across the board of the $320 million.

Senator McCARTHY: When you say that there was a general uplift, what was the general uplift for each of them?

Mr Smith: It averaged around $1,800 per resident.

Senator McCARTHY: When was that paid?
Mr Smith: Between March and June 2019.

Senator McCarthy: On top of the $1,800 per resident, is there a 30 per cent supplement on the viability and homelessness on top of that?

Mr Smith: Yes.

Senator McCarthy: Could you provide a full list, including the funding amounts, for the committee?

Mr Smith: I'm sorry, a full list of the providers that received those supplements?

Senator McCarthy: That's correct, yes.

Mr Smith: Yes, we can do that. I'd have to take that on notice, but yes.

Senator McCarthy: Why was the decision made and who made this decision to allocate this funding over an 18-month period?

Mr Smith: The funding was paid out over a three-month period, and that was a decision of government.

Senator McCarthy: So it's paid much earlier, or was it always intended for three months?

Mr Smith: It was paid as, I guess, an up-front payment. It provided an immediate substantial injection to the sector, recognising the pressures that have been identified by ACFA in particular, and Mr Callaghan referred to his update report in 2018. So it was a direct response to that. And the media release referred to an 18-month period and that's referring to the fact that it was an up-front injection really, a substantial injection, to support the sector over a period of time.

Senator McCarthy: How did the government come up with a $1,800 per resident injection? What was the thinking behind that amount?

Mr Smith: I think that goes back to your earlier question. That was a decision of government. The department provided advice in the deliberative process.

Senator McCarthy: Minister, what was the thinking behind the $1,800? How did you get to that number?

Senator Colbeck: As I said before, that was a decision of the government at the time, based on advice from the department. We can go back over that cycle as many times as you like, but that's the position.

Senator McCarthy: We're talking now specifically about the $1,800. What was the advice from the department and why did you come to that?

Senator Colbeck: That was the decision of government at the time.

Senator McCarthy: So how did you come to that decision?

Ms Beauchamp: Of course, it is cabinet-in-confidence but we drew on a number of reports—for example, the Mike Callaghan report, StewartBrown and others; so we did some work internally—and I can't go into the details of that.

Senator McCarthy: Does that include the department giving advice to the minister on the content of the Stewart Brown report, when we talk about the reports?

Ms Beauchamp: We have provided advice, yes.
Senator McCARTHY: Did the department give advice to the minister about the content of StewartBrown's March 2019 report that concluded the following—and I've got a couple of points here, Miss Beauchamp: '67 per cent of outer regional, rural and remote facilities reported an earnings before tax loss and 43 per cent recorded a cash loss'?

Ms Beauchamp: We have provided advice on the StewartBrown report, yes.

Senator McCARTHY: And that also includes the 45.6 per cent of residential facilities that recorded a negative operating result?

Ms Beauchamp: As I said, we've provided advice on the StewartBrown report.

Senator McCARTHY: That would also obviously include the 19.75 per cent of residential facilities representing a cash loss?

Ms Beauchamp: There are a number of proposals in the StewartBrown report and we provided advice on those.

Senator McCARTHY: Did the department give advice to the minister about the content of StewartBrown's June 2019 report that was released last week? It concluded the following:

The financial performance of the aged care sector, and specifically the residential care segment continues to be a significant concern. The residential care operating results for FY 19 declined in real terms even after the $320 million subsidy injection for the last quarter. Without further targeted and required funding initiatives, including from both the government and consumer, the forecast trends are such that the continued viability of a number of improved providers may be under substantial strain.

How is the department measuring the $320 million allocation and its effect within the residential aged care system?

Ms Beauchamp: I think the StewartBrown report made comments about the potential impact if that injection of funding had not been made, and we provided advice to the minister on that.

Senator McCARTHY: I'm sorry, Miss Beauchamp, I'd like to understand just how you're measuring the allocation and its effect within the residential aged care system of the $320 million.

Ms Beauchamp: As I mentioned, we're drawing on experts' advice, including Mike Callaghan and StewartBrown.

Senator Colbeck: It will be reflected, I would assume, in the funding authority's next report, which is currently due next year.

Senator McCARTHY: When is it due, Minister?

Senator Colbeck: In the same cycle as the one that Senator Watt referred to a moment ago.

Senator McCARTHY: Has the department provided any further advice to government on more payments being needed?

Ms Beauchamp: We provide advice on a range of matters and, indeed, on the aged care sector we provide lots of advice.

Senator McCARTHY: On more payments? Is that a yes?

Ms Beauchamp: Along with other advice.

Senator McCARTHY: When was that advice given?
Ms Beauchamp: I won't go into the details of the advice we provide in deliberative processes but we provide advice on a range of matters.

Senator McCarthy: You've given the government advice on more payments? I take that as part of that response.

Ms Beauchamp: I'm not going to say what the nature of the advice is.

Senator McCarthy: Given the figures in the March and June StewartBrown reports about regional, rural and remote facilities, how is the department monitoring their viability?

Ms Beauchamp: I think Mr Smith has spoken about the extra targeting by government in terms of the viability supplements and supplements for rural and remote.

Senator McCarthy: Mr Smith has certainly identified the payments that are going to those areas. I'm just interested to know how you are monitoring it, that's all.

Ms Beauchamp: We will look at the impact of those payments and a range of other payments and, indeed, the overall ACFI payments and the changes that are being made. We'll do that in the cycle of the Aged Care Finance Authority and the StewartBrown reports that provide the actual evidence to support our advice.

Senator McCarthy: I don't think it's a hard question; it's more about the indicators of how you monitor it. Is it a case of fewer people coming into the system? There must be some key indicators that you can mention? It's not a hard—

Ms Beauchamp: I think the StewartBrown report and the finance authority report do, indeed, provide quite comprehensive evidence and statistics on what's happening in the residential aged care sector. And we use that expert advice in terms of providing support and further advice to ministers. Yes, I agree with you. It's not a hard—

Senator McCarthy: You just leave it to the experts to give you that advice?

Ms Beauchamp: Indeed.

Senator McCarthy: So the department itself doesn't have its own system set up to monitor long term?

Ms Beauchamp: We have advisers and support, particularly in Mr Murray's area, that do look at the impacts and assess the ACFI funding tool and review the funding arrangements going through that tool, yes.

Senator McCarthy: Mr Smith, I can see that you are wanting to speak here.

Mr Smith: It's really to pick up on the secretary's point that we do monitor the financial performance of providers. The annual returns are actually due at 31 October this year for the last financial year. They'll be then analysed by Mr Murray's team. They are for the purpose of reporting to ACFA, who then makes its own assessments as to the performance of the sector. That also gives an opportunity to identify individual providers that might be of concern, I suppose, and then an opportunity to look into that in some more detail. In addition to that, there are the quarterly StewartBrown reports which do feed into the overall analysis, and Mr Callaghan has talked in detail about some of the consultations he has held and does hold in relation to the ongoing viability of the sector. The Aged Care Finance Authority meets every six weeks and certainly all of those qualitative indicators also feed into a broader analysis that ACFA undertakes for government, and the department is a part of those discussions.
Senator McCarthy: What work is being undertaken to ensure that the more than 200,000 older Australians in residential aged care are in a viable facility?

Ms Beauchamp: I think, as Mr Murray said earlier—and I'll let the officers expand on it—our focus is absolutely the quality and safety of care of residential aged care recipients. We're actually going through a trial of a new funding model for a potential replacement of ACFI which absolutely focuses on the needs of our care recipients and that will absolutely look at what is the mix and match of skills and other supports required to ensure the quality and safety of care in residential aged care. We are going through that process at the moment and there'll be a trial of the new funding model. And I think already there's been commentary made about the existing tool in terms of some of the inadequacies of that. And we'll be trialling that with 10,000 care recipients probably from next month until April to see if that better reflects the needs of our aged care recipients in residential aged care facilities.

CHAIR: Senator McCarthy, I might pass the questions over to Senator Griff who's been waiting very patiently.

Senator McCarthy: Okay.

Senator Griff: My question initially relates to the ABC story of a couple of months ago regarding Bupa, who was described by an aged care advocacy group as being 'too big to fail, with 6,500 residents in 72 homes across Australia'. The article at the time reported that more than half of Bupa's nursing homes fail to meet all the health and safety standards. Can you tell us what those failed standards were?

Senator Colbeck: Perhaps I can say that I think there are some inaccuracies in that story around the quantum—not to excuse Bupa at all. There is no excuse for the situation that they're in, but I think there is some contest around the actual numbers within the news reports. But I'm on the public record as saying—

Senator Griff: Yes, you're saying that it's totally unacceptable.

Senator Colbeck: that it's totally unacceptable and I'm on the public record as saying I don't regard them as too big to fail. I regard them as big enough to comply and with resources enough to comply, and that's what I and the government expect of an organisation such as Bupa. But the officers can give you more detailed information around some of those elements.

Ms Beauchamp: When services are sanctioned, the details of those sanctions are made public on our website.

Senator Griff: At the time of that article, 13 Bupa homes had been sanctioned. And looking at the website today, it says that there are still seven that have been sanctioned. My understanding is that means that they've lost funding for new residents. Is that the case when they are sanctioned?

Ms Beauchamp: That's one of the sanction requirements, yes.

Senator Griff: Can you provide examples of the current sanctions against Bupa? As I've said, I understand that it's seven at the moment. There's Bupa Campbelltown, Bupa Sterling, Bupa Berry, Eden, Roseville, Seaforth and Traralgon. It's still quite a substantial number of months down the track.

Ms Beauchamp: Yes.

Mr Hallinan: Just to confirm, there are currently nine open sanctions on the Bupa homes.
Senator GRIFF: So the website is incorrect?

Mr Hallinan: No, the website is correct. There are a couple of homes that have got multiple sanctions. There are sanctions on Berry, Berwick, Campbelltown and two on Eden, and on Roseville, Seaforth, Stirling and Traralgon. The specifics of those sanctions, I think, are available publicly on the web and that does outline in each of those circumstances what the sanctions are for.

Senator GRIFF: I will refer to those. Some smaller nursing homes—and there was one that was given to me as an example, which is Earle Haven nursing home—have been shut down for similar infractions, if you like. Why is it that Bupa homes are allowed to remain open? Do you have a greater degree of tolerance for poor care because of their size?

Mr Hallinan: No.

Senator Colbeck: Earle Haven wasn't closed for that purpose. I'm sure we'll have some more conversations around it later with Senator Watt but the circumstances at Earle Haven are very, very different to the circumstances at Bupa and I'm not sure that you could reasonably make a comparison in a direct sense.

Senator GRIFF: Fair enough, but is Bupa treated differently by the department because of its size?

Mr Hallinan: Only insofar as we might meet more regularly with Bupa as a result of the size of the organisation and the number of sanctions imposed on it.

Senator GRIFF: What would it take for a large operator that has had a number of failures to be, if you like, asked to exit the system?

Mr Hallinan: That's a hypothetical question and I can't provide an answer to it.

Senator Colbeck: It's probably worth giving you an indication of the engagement we have with Bupa, because it is quite significant and regular. Perhaps the officers can give you some advice as to what we are doing in that sense, including a requirement for them to employ nurse administrators—I think that's the right term—within the facilities so that they can assist them in lifting the standard to compliance, including, I think, weekly meetings with the department and regular meetings with the commissioner, who has arrived in a timely sense at the scene.

Ms Beauchamp: Perhaps I can add to that before I hand over to Ms Anderson, who oversights the accreditation process as well. I have personally met with the chair and the chief executive to express our concerns, wanting to ensure that there's a sense of urgency for Bupa to return as quickly as possible to not having sanctions and notices of non-compliance. We've made it clear that we want them to come up to scratch. We don't give them any favours and we treat them all the same.

Senator GRIFF: My understanding with the sanctions is that this has been going on for two years effectively. How long do you keep this going, when the group obviously has endemic issues?

Ms Beauchamp: We look at each site individually. Our primary responsibility is the health and safety of the residents and making sure they're well looked after. As the minister has pointed out, there are a number of arrangements that we put in place, whether it's clinical
oversight or administrative oversight, and we stop funding to make sure that they bring their services up to scratch. I think the officers meet regularly with the CEO as well.

Mr Hallinan: It would be worth noting that, in the case of Bupa, they have had a greater number of facilities fall into sanction than you’d expect, given the size and scope of the organisation. We’ve worked very closely with them over the last six or eight months. They’ve established new general management arrangements within Australia, they’ve established new regional management arrangements within Australia, they’ve established different clinical governance arrangements on their sites and they’ve also stabilised many of their staffing arrangements throughout the sites in particular that are under sanction. Officers to my right have regular conversations with Bupa; I think we have a weekly meeting with them. I’ve met with the CEO of Bupa and with the general manager for Australia on numerous occasions in the last few months.

Senator Griff: Does it also concern you that the ATO considers them to be an at-risk entity in relation to lack of disclosure of their accounts and the like?

Mr Hallinan: The financial information that they disclose to us, through the Aged Care Act and their reporting requirements to us, shows that they are in a reasonable financial state for the purposes of delivery of aged-care services. Broader issues of concern for the ATO would be a question for them.

Senator Griff: Mr Speed, would you like to add to that?

Mr Speed: We are meeting with Bupa on a weekly basis and officers are engaging with Bupa to monitor return to compliance, including receiving reports from them.

Senator Griff: I have a couple of questions in relation to falls, which I’ve asked on other occasions. We know that falls and their consequences are one of the largest causes of hospitalisation for the elderly, especially in aged care. Is the department aware of the US Centre for Disease Control and Prevention’s STEADI program—STEADI stands for Stopping Elderly Accidents, Deaths and Injuries?

Ms Laffan: No, I’m not aware of that study.

Senator Griff: Is it definitely a program that’s worth looking at by the department. Does the department have any falls prevention programs currently implemented? In response to a question on notice that we gave you previously, you said you would have something in place by July 2021.

Ms Laffan: I believe that refers to the work we’re doing on establishing a new quality indicator on falls and fractures. In addition, we have the quality standards which specifically talk about the management of high-prevalence, high-impact risks, and falls are one of those. The Australian Commission on Safety and Quality in Health Care has also published a resource about preventing falls and harm from falls in older people.

Senator Griff: Are you running any programs for GPs and nurses to help them implement falls protection?

Ms Laffan: Not to my knowledge.

Senator Griff: Why is that? Would that not be important, given the significant effect of falls?
Mr Hallinan: General practice training programs are traditionally managed through the RACGP, the College of General Practitioners, through a CPD model—continuing professional development. I can take on notice for you the extent to which falls prevention activities might be covered through CPD arrangements of the college.

Senator GRIFF: I would appreciate that; thank you.

Senator SIEWERT: Perhaps I can go back to some of the viability issues. If Senator McCarthy has already asked them, tell me to go and look at the Hansard; I've been next door at another appointment. I want to focus on remote and very remote aged-care services; did we cover those earlier?

Mr Hallinan: There was some discussion around them.

Senator SIEWERT: Can I ask about the number—tell me where to go and look—of for-profit versus not-for-profit providers in remote and very remote areas?

Mr Smith: We'll have that. It'll be in the Aged Care Financing Authority annual report. It might take us a little time to locate it specifically, or we could take that on notice and come back to you.

Senator SIEWERT: If you could tell me, it would be important because it relates to some of the other issues.

Mr Smith: Sure.

Senator SIEWERT: Do you look at where organisations cross-subsidise from their other operations to support operations in remote and very remote areas?

Mr Murray: We don't get that level of granular detail. From providers, we get their residential care segment level, but we don't get service level information; so we can't make that comparison on the data we receive.

Senator SIEWERT: You have no oversight, then, of how much the organisations are cross-subsidising other services they are providing. In other words, you don't get a true picture of the cost of delivery of those services. Is that correct?

Mr Murray: We don't get service level information. If a provider has a number of services in a metro area and a number of services in a remote area, we get that aggregated together, so we can't look at the individual service level information.

Senator SIEWERT: Have you thought of looking at that? I get told there's a whole lot of non-viable services being subsidised by other operations, particularly by not-for-profit organisations.

Ms Beauchamp: We will get a clearer picture of that at the end of October, when we have a good look at their financial statements.

Senator SIEWERT: Okay—overarching. So you will put that lens across it?

Ms Beauchamp: Provider organisations, yes.

Senator SIEWERT: For those in rural—

Mr Murray: It's only at the final level.

Ms Beauchamp: Yes.
Senator SIEWERT: I am interested in rural, but I'm interested particularly in remote and very remote.

Mr Murray: We can look at that from the provider level but, at the moment, we don't get the granular level of detail at the service level to make very detailed analysis of what that level of cross-subsidisation information may be.

Senator SIEWERT: So that I don't go away having misunderstood you, Ms Beauchamp, do I understand that, when you've done that further analysis, you'll get an idea about how much extra organisations are tipping in from cross-subsidising remote and, therefore, get a better idea of what the true cost is?

Ms Beauchamp: Looking at their accounts, we'll get a better idea of where the money has gone and how they're funding their services at a provider level, yes.

Senator Colbeck: But not necessarily down to a granular level of individual service. A provider might have a number of services across a number of jurisdictions—say, metro verses remote and very remote. The provider as a whole would provide data, but not necessarily at the granular level.

Senator SIEWERT: So I have misunderstood; that's why I was trying to clarify. I'm trying to get an idea about whether you will have a picture of how badly those services are doing; that is the bottom line.

Mr Murray: The StewartBrown information is at a service level. That's based on their survey, so it's a private sector firm running that survey. That information doesn't come to us specifically. We can see the results in their reports and make assumptions on that, which is what the secretary's referring to. The other thing that is of relevance in this area is the RUCS study that was done by the University of Wollongong. That study looked into underlying cost differences in different areas and found that there were higher costs in those remote areas. That goes to the general issue around costs in those areas. Your cross-subsidisation issue doesn't specifically go into it.

Senator SIEWERT: That's what I'm trying to find out. I take your point about the RUCS study, but it doesn't take Einstein to work out that it costs more to deliver services in remote and very remote areas. How many services, remote and very remote, are not funded through the NATSI Flex program and are just relying on ACFI's supplements for funding under the Home Care Packages Program?

Mr Murray: We have that information, but I would have to take it on notice to get the actual numbers for you.

Senator SIEWERT: Okay, if you could take that on notice. I'm crossing over into NATSI Flex questions; is that okay?

Ms Beauchamp: Yes.

Senator SIEWERT: My understanding is that only three in 10 providers in the Northern Territory have NATSI Flex funding; is that correct?

Mr Smith: My colleague who has a more detailed knowledge of the program will come to the table. I'm not sure of the proportion, but certainly the majority of providers would be funded through mainstream and not through the NATSI Flex program.

Senator SIEWERT: I'm talking about in the Northern Territory.
Mr Smith: In the Northern Territory and generally, yes.

Senator SIEWERT: Can you tell me why—if I'm correct in the three in 10—only three in 10 of the providers are able to access NATSI Flex?

Mr Smith: That's been a function of the way the program was established with the funding available under the program. There has been a recent significant expansion of that and that expansion is currently underway. We've, I think, introduced an additional 76 places across Australia that are now funded through the NATSI Flex program for residential care and 512 for home care. Another two funding rounds are to occur in this current financial year and the next financial year, which will focus on further expansion to home and residential care. That's in terms of both providers that wish to establish new services or to expand existing NATSI Flex services and also those providers that may be mainstream providers who want to convert their mainstream funding into NATSI Flex funding to give them the flexibility of the block funding that comes under that program. Those rounds will occur over the next couple of years. It's an ongoing expansion.

Senator SIEWERT: You've said 'the next couple of years'.

Mr Smith: That is the current financial year and the next financial year. We ran two rounds in the last financial year and we have rounds to occur this year and next year.

Senator SIEWERT: So the 76 is how many are out there at the moment.

Mr Smith: That's the additional places that have just been funded; correct.

Senator SIEWERT: Just funded.

Mr Smith: Yes.

Senator SIEWERT: Do you mean that they've just gone into the marketplace?

Mr Smith: Correct.

Senator SIEWERT: And with an extra 512 coming on with home care.

Mr Smith: Yes, correct.

Senator SIEWERT: How many home care are there at the moment in NATSI Flex?

Mr Smith: In total?

Senator SIEWERT: Yes.

Mr Smith: We can get that. I'm sorry, but I don't have that in front of me.

Senator SIEWERT: If you could get that, it would be appreciated; thank you. My understanding is that providers are calling for a $10 increase to keep regional and remote services afloat while the royal commission is undertaken. There will be, I suspect, changes after the royal commission. Have you heard these calls and have you been responding to them? Maybe I need to ask this of the minister.

Ms Beauchamp: Perhaps I can clarify. Did you say $10 per resident per day?

Senator SIEWERT: Yes.

Senator Colbeck: For a particular service?

Senator SIEWERT: They're saying particularly for regional and remote, and particularly focused on remote services.
Senator Colbeck: There have been a number of entreaties from industry around viability and additional payments and I've been engaged with industry in conversations around that.

Senator SIEWERT: You are engaging?

Senator Colbeck: I have engaged, yes, and I continue to engage.

Senator SIEWERT: Will you be doing more than engaging in terms of making a decision; and, if so, do you have a timeframe for that?

Senator Colbeck: I will continue to engage with industry. I'm aware of the issues around viability and all of the issues that input into it. We had some conversation earlier with Senator Watt around the ACFI report. A range of issues go into what's driving the viability issues in the sector at the moment, their claims around the level of funding in residential aged care being one of them. There are also issues around occupancy, which has dropped away by about six or seven per cent over the last five or six years. It was about 97 per cent and has dropped back to about 90, and that is having an impact on the viability of some providers. We're also doing some work around management capacity, which is another clear indicator of viability of the sector. So we're doing a number of things and we already have in place programs to address that, but we're looking broadly across all of the indicators around viability.

Senator SIEWERT: Okay.

CHAIR: As it is 11 o'clock, we will take a break.

Ms Beauchamp: Sorry, I was just going to add that, in terms of the dollars per day for people in residential aged care, the trial of the new funding instrument will give us more information, particularly that differentiation between rural and remote and metro.

Senator SIEWERT: When we come back, I'll have more questions.

CHAIR: That's fine; I'm happy with that. We will suspend for 15 minutes.

Proceedings suspended from 11:01 to 11:15

CHAIR: We will continue with outcome 6. Senator Siewert is continuing with questions.

Senator SIEWERT: You were going to give me some data; did you manage to find it?

Mr Smith: No; we're still tracking that down. I was mistaken. This report doesn't have that particular breakdown, but we are looking for that; we have people working on it.

Senator SIEWERT: Thank you. In terms of the release of new residential places versus home care, can you give us the full number of available places that are currently funded under NATSIFACP for both residential and—

Mr Smith: The full amount. I'm not sure that we have that in front of us; again we have people working on that.

Senator SIEWERT: You'll take that on notice?

Mr Smith: We'll take that on notice and see what we can get for you quickly.

Senator SIEWERT: Do you keep details on how many of the remote and very remote services are actually run by Aboriginal organisations?

Mr Smith: That information would be available to us.

Mr Barden: We do have that information and we could draw that together for you, on notice.
Senator SIEWERT: If you could provide that on notice, it would be appreciated—both for residential and for home care services.

Mr Barden: Yes.

Senator SIEWERT: We were talking about issues around viability, particularly for regional and remote areas. In terms of the work that's being done, can you drill down into just what the situation is, specifically in remote areas, with the work that you're doing now?

Mr Smith: Yes. Through the RUC study that we've referred to and the ongoing work around the trial, that information would be available. It does split out, by remoteness, the different kinds of cost pressures and the additional costs that flow to those more remote services. We'll continue to get better and better information about that. Certainly, the indications from the initial study are that services particularly operating in remote and very remote areas do have additional costs, and there's a weighting applied to those services. We already have some of that information and we'll continue to get more.

Senator SIEWERT: As we've already established that you don't have quite that level of detail, will you be able to go back to providers and ask them specifically for the detail around how much they are cross-subsidising, to get a full picture of how those particular facilities are staying afloat?

Mr Smith: It's not required of them to provide us with that information. Certainly, in theory, you could go to the providers and ask them that question. Anecdotally, we certainly hear that. In discussions that I've had with providers who deliver services from metropolitan through to very remote—your big not-for-profit providers—they do talk about the need to cross-subsidise. Government has acknowledged, and the department certainly acknowledges, the additional costs that do exist in relation to remote and very remote areas. That's why the viability supplement has been in place for a number of years and that's why it was increased by 30 per cent very recently.

Senator SIEWERT: I understand that, and that was appreciated. But, from what I further understand from discussions with them, it's not doing enough to address the issues of non-viability in remote and very remote. You've taken on notice the issue around the for-profits versus the not-for-profits in remote and very remote. Can I add regional to that, please? I understand that there are very few for-profit organisations working anywhere in the bush.

Mr Hallinan: We'll take that on notice and try to provide a breakdown using a geographic classification, a modified Monash or something.

Senator SIEWERT: Can you make sure that it is intelligible for those of us who aren't always familiar with the different versions of geographic classifications?

Mr Hallinan: We'll give you the best one. We could probably do it in two ways, but we'll see.

Mr Barden: I could give you now the breakdown of home care and residential places through the NATSIFACP program.

Senator SIEWERT: That would be brilliant; thank you.

Mr Barden: On 30 June 2019 a total of 1,072 places were delivered through NATSIFACP. Of those, there were 598 home care places and 474 residential care places. I should be clear in pointing out that the places are a vehicle through which care can be given
and, more importantly, through which the funding passes to the service provider. There are 474 residential care places, but it doesn't limit it to the provision only to 474 people. Also it means that, should there be in a particular location a need to provide more residential care than there are places available to a service but they have a surplus of funds from their home care funding, they can use that funding flexibly and meet the needs of the local community at that particular point in time.

**Senator SIEWERT:** I think I get that. You're providing that number of packages but they're flexible in the way they can be used. Is that an accurate reflection of your understanding of what happens?

**Mr Barden:** It is, yes.

**Senator SIEWERT:** And now coming into the market are 76 home care packages, with 512 still to come.

**Mr Smith:** Just to be clear regarding my earlier evidence about that, that is the national figure.

**Senator SIEWERT:** Yes. So this is just in the NT.

**Mr Smith:** No. Those figures that you just quoted are the national figures. I wanted that to be clear, because I know you were asking about the NT. When I referenced the 76 and the 512, they were national figures.

**Senator SIEWERT:** Are the figures I got just then national or NT?

**Mr Barden:** They're national. I can give you an NT set of numbers, if you'd like.

**Senator SIEWERT:** Yes, that would be appreciated.

**Mr Barden:** In the Northern Territory, on the same date of 30 June 2019, there were a total of 461 places through NATSIFACP. Of those, 305 were home care and 156 were residential care.

**Senator SIEWERT:** Thank you very much for that; it's much appreciated.

**Senator WATT:** We've still got a few more in program 6.1. I want to begin by dealing with matters that have arisen in the royal commission into aged care in the last few days. Minister, are you across the testimony of Ms Beauchamp at the aged care royal commission last Friday?

**Senator Colbeck:** In relation to what, specifically?

**Senator WATT:** In general terms, are you aware of her testimony?

**Senator Colbeck:** I saw some of it but not all of it.

**Senator WATT:** Are you aware of the closing remarks from counsel assisting the inquiry?

**Senator Colbeck:** I haven't seen the closing remarks, but I saw some of Ms Beauchamp's testimony.

**Senator WATT:** You have not seen the closing remarks from the counsel assisting the inquiry?

**Senator Colbeck:** No.

**Senator WATT:** How closely are you monitoring the royal commission into aged care?
Senator Colbeck: I get reports every day, but I don't watch every element of it, obviously. I have other things to do.

Senator WATT: You're not aware of what the—

Senator Colbeck: I'm aware that some comments were made at the end—Ms Beauchamp and I have discussed that—in relation to her testimony. I don't know the specifics of it; I haven't read the specifics of it.

Senator WATT: But you're not aware of what senior counsel assisting the royal commission had to say on Friday?

Senator Colbeck: I'm aware that he made some comments. I'm not specifically aware of the full details; I haven't read them.

Senator WATT: Could I remind you of some of the things that senior counsel had to say—because, frankly, even I was shocked by what he had to say, despite having followed aged care for some time now. Again, this is senior counsel assisting the royal commission, who has been involved from day one and has reviewed all of the evidence and has heard from all of the witnesses. This is what he's got to say about the aged-care system:

On current trends, the entire system is under serious threat, and without fundamental change we're concerned the system will fail.

Can there be any greater condemnation of your government's administration of the aged-care system for the last six to seven years than that?

Senator Colbeck: I'll take the comments from the counsel as you've read them, but I would reject the suggestion that there's no movement in government policy or that we're not actually doing anything. As I think I've commented a number of times, there are a number of reforms that we are continuing to implement. Bear in mind that we actually called the royal commission so that we could have this forensic look at the aged-care sector; we considered it was that important that we do it, and that's why we called the royal commission.

As a part of that process, we've continued to implement a number of reforms—for example, the introduction of the new quality and safety commission, which started on 1 January this year; the introduction of new quality standards, which came into place on 1 July this year; the residents charter; and new standards around restraint, to name just a few of the things that we've done. Of course, we're working our way through the process of looking at a new funding tool because, as you've quite rightly discussed this morning, there are issues around viability of the sector and how it's paid, and we want to make sure that the industry is not only viable but also continues to provide quality care.

We are quite cognisant of the fact that there are some issues in the sector to be dealt with, and we are working our way through dealing with those things. We look forward to the interim report, which will come down next week, and of course the continuation of the royal commission. But it needs to be remembered that we called the royal commission specifically to do the work that it's doing now, as uncomfortable as it might be for any of us.

Senator WATT: Why has it taken six to seven years of your government being in power—two terms in office—for you to start making some of the changes to stop the system failing?
Senator Colbeck: I think you've just made the point for me. We are actually doing those things.

Senator WATT: Why has it taken six to seven years?

Senator Colbeck: You can reflect on that as much as you'd like.

Senator WATT: I think it's a reasonable question.

Senator Colbeck: We called the royal commission to undertake the investigation that it's doing. There have been a number of reviews—Productivity Commission's, the Tune review—

Senator WATT: Yes, and you haven't done anything about it.

Senator Colbeck: That's not true.

Senator WATT: You've been in government for six to seven years and there's been report after report and Senate inquiry after Senate inquiry.

Senator Colbeck: You might like to characterise it that way, but clearly—

Senator WATT: It's not me.

Senator Colbeck: you have just accepted, by your own comments—

Senator WATT: The counsel assisting the royal commission says the system is going to fail. It's not me.

Senator Colbeck: You have just accepted, by your own comments, Senator Watt—

Senator WATT: That you've done nothing for six to seven years.

Senator Colbeck: that we are implementing reforms that will change the aged-care sector.

Of course, we will respond to the royal commission report once it's completed. So you've accepted, by your own words, that we are acting and, clearly—

Senator WATT: No. What I've accepted is that the system is about to fail, because that's what senior counsel assisting the royal commission was reporting to the royal commission—

Senator Colbeck: He said—

Senator WATT: on Friday, and you've got to be reflecting on the fact that you guys have stuffed this up. You've cut funding, you haven't put workforce in and you haven't responded to any of these inquiries and now the system is on the brink of collapse.

Senator Colbeck: That's the view of the counsel—

Senator WATT: Is he wrong?

Senator Colbeck: I am not going to reflect on—

Senator WATT: Is he wrong?

Senator Colbeck: Perhaps you'll let me finish answering the question. I will not reflect on the view of the counsel and I will put the government's position on the table, as I have done. You have acknowledged, by your own comments this morning, that we are working our way through a series of reforms to improve the aged-care sector, as it needs. In fact those reforms are in direct response to things like the Carnell-Paterson review, the implementation of the next stage of development of the new quality and safety commissioner with the legislation that we currently have in the parliament, on which I look forward to your support. There are a range of things that we are doing right now to improve the aged-care system because we
recognise, as demonstrated by our calling of the royal commission, that there are things that need to be done and we continue to act while the royal commission continues.

Senator WATT: If everything is okay, you've got it all in hand and you're taking—

Senator Colbeck: That's not what I've said. Don't misrepresent what I've said. I've said—

Senator WATT: If you're taking all of these actions and doing all of these things—

Senator Colbeck: The whole point of those things is to improve the system.

Senator WATT: If you're right and you're doing all of these things to fix up the system from the failings that your government has overseen for six to seven years, then why does counsel assisting say to the royal commission, 'The Commonwealth appears, on the evidence you have heard, to be missing in action'—missing in action?

Senator Colbeck: I will put on the record what we're doing. As I've said, I will not reflect on the commission or the comments of counsel but I will put on the record what we are doing and will continue to do because—

Senator WATT: You can't be doing much, if you're missing in action.

Senator Colbeck: We all accept—

Senator WATT: If people are missing in action, it means that they're not doing anything.

Senator Colbeck: I will put on the record what we're doing—and I've clearly done that—and what we will continue to do. We have said that we will continue to act to reform this sector while the royal commission continues, and we will do that. That can become part of the consideration of the royal commission as it continues over the next 12 months. We look forward to that process. We called the royal commission because we recognised—

Senator WATT: You called the royal commission because—

CHAIR: Senator Watts, please let the minister answer.

Senator Colbeck: We called the royal commission because we recognised that things—

Senator WATT: You called the royal commission because the aged-care sector—

CHAIR: Senator Watts!

Senator WATT: was screaming for it and it had support from a range of other parties. Let's be honest.

Senator Colbeck: We called it because we recognised that there were things that needed to be done. We are also responding to other processes, like the Carnell-Paterson review, which called for a number of reforms, which we are implementing and continue to implement, and we look forward to the opposition's support as we continue that process.

Senator WATT: Were you are aware of these comments from counsel assisting before I read them to you today?

Senator Colbeck: I had heard those two comments, yes.

Senator WATT: The other thing that counsel assisting had to say was:

The Commonwealth also needs to be active. Funding from its aged care workforce programs has been stripped.

Over and over again this morning, in previous hearings of this committee, you and other government ministers have tried to deny these arguments that funding has been cut. It's there
in black and white: 'Funding from its aged care workforce programs has been stripped. ' Can you just finally accept that the cuts that your government has made to aged care are responsible for so many of the problems that we are seeing in this sector? This is the counsel assisting the royal commission.

**Senator Colbeck:** Funding to the aged-care sector has continued to increase every year.

**Senator WATT:** Why is he saying that funding has been stripped? Don't you believe this bloke? This bloke is independent.

**Senator Colbeck:** Funding to the aged-care sector has continued to increase every year.

**Senator WATT:** He's not political like you or I.

**Senator Colbeck:** And I would agree with counsel that there is a significant workforce piece to be undertaken.

**Senator WATT:** He says that funding has been stripped from the aged-care workforce. Are you saying that he's wrong?

**Senator Colbeck:** Funding to the aged-care sector has continued to increase every year, despite claims from the opposition—

**Senator WATT:** So he's wrong?

**CHAIR:** Senator Watt, please let the minister answer.

**Senator WATT:** Should he go to jail for misleading the royal commission?

**Senator Colbeck:** That's a ridiculous comment.

**Senator WATT:** You're disputing what he's saying?

**CHAIR:** Senator Watt!

**Senator WATT:** A barrister who's been engaged, who is independent, is saying—

**CHAIR:** Senator Watt, please let the minister answer.

**Senator Colbeck:** I'm stating clearly that funding to the aged-care sector has continued to increase every year.

**Senator WATT:** So he's lying?

**Senator Colbeck:** Are there issues around workforce? Yes, there are. And there are significant issues around workforce that we will need to address. And one of the things that have occurred in that space is the commencement of the aged-care workforce committee, which has been set up by private members of the sector, as recommended by the Pollaers report. That work has commenced and that group is commencing its deliberations as well.

**Senator WATT:** Why have you stripped funding from the aged-care workforce programs?

**Senator Colbeck:** I don't accept that we have.

**Senator WATT:** Is he in contempt of the royal commission for misleading—

**Senator Colbeck:** We have increased funding—

**Senator WATT:** That's a pretty serious accusation.

**CHAIR:** Senator Watt, please!
Senator WATT: It's a pretty serious accusation to say that the senior counsel assisting the royal commission is misleading the royal commission and you're saying that he's wrong.

Senator Colbeck: That's not what I said and you're putting words in my mouth.

Senator WATT: He's saying that funding has been stripped but you're saying that's wrong and the funding is going up.

Senator Colbeck: Funding to the aged-care sector has increased every year.

Senator O'NEILL: You cannot both be right.

Senator Colbeck: Funding to the aged-care sector has increased every year. It's a simple fact. Read the budget papers.

Senator O'NEILL: He's lying or you're lying.

Senator Colbeck: Funding to the aged-care sector has increased every year. It's a simple fact. Read the budget papers.

Senator WATT: Then why would the senior counsel be telling the royal commission that funding has been stripped?

Senator DEAN SMITH: Minister, I think context is very important. I've just done a quick Google search. Labor's costing document from the election—

Senator WATT: Mate, you've been in power for six or seven years!

Senator DEAN SMITH: If I recall, there was no attribution at all in Labor's costing documents for aged-care workforce issues—none whatsoever.

Senator WATT: You have been in power. When are you going to—

Senator Colbeck: Senator Smith, that is exactly true. The Labor Party at the election put no dollars into increased funding for aged-care workforce, zero, despite—

Senator DEAN SMITH: So that comment by the counsel assisting the royal commission would be equally true of a Labor government, had it won?

CHAIR: I think we need to pull this back to questions.

If we're going to talk about 2012-13, you might recall that Labor had a $1.5 billion workforce compact that was cut by—remember this bloke—Tony Abbott. Do you remember him?

CHAIR: I think we'll go back to some questions. I'm just conscious that Senator Roberts has been waiting. He actually was waiting beforehand. We could come back to you shortly.

Senator ROBERTS: Thank you.

Senator WATT: Just to finalise this—

CHAIR: We'll just have this last question.
Senator WATT: The senior counsel concluded this segment by saying, ‘The Commonwealth's failure to lead in aged care’—failure, fail—‘has contributed to the distressing outcomes for care recipients, their families and workers that you continue to hear evidence about.’ Again, it's black and white. When are you going to take responsibility and just be honest and say your failures are the reasons that we keep seeing story after story after story of older Australians not getting the care they deserve, getting appalling food, hygiene standards and the rest of it? It's not about the staff. They are working incredibly hard in difficult circumstances. He hasn't blamed the staff, he hasn't blamed the providers. It's the Commonwealth's failure that has caused this. Please will you take responsibility?

Senator Colbeck: As I said to you before, I'm not going to reflect on the commission, because they are doing the job we asked them to do. And that's why—

Senator O'NEILL: Tell the truth instead of a cover-up.

Senator Colbeck: Perhaps you could just stop interjecting and let me answer the question, Senator O'Neill. You're very rude. Senator Watt, I will not reflect on the commission. We set them up to do the job that they are doing, as uncomfortable as it might be for any of us. That's why they're there.

Senator WATT: You're the Commonwealth!

Senator Colbeck: That's exactly right. That's why they're there. We set them up to do the job that they're doing, as uncomfortable as it might be for us. We look forward to their interim report, which is due next month, and then we subsequently look forward to the final report, which will provide us with the forensic review of the sector that we believe that it needed. And in the interim we will continue to implement reforms based on reports, such as Carnell-Paterson and Tune—to continue to improve the system, because we recognise that it needs improvement. We know that there are elements that are bad but can I say that there is a lot that is good about this sector as well. You've mentioned the staff, and Senator Siewert has talked about some of the providers across the country in rural and regional. I am very cautious in portraying the entire sector in a completely negative light because I know that it's not. Are there problems that need to be dealt with? Absolutely there are; absolutely there are. That's why we continue to implement the reforms that we do. That's why we called the royal commission—to shed some light on the issues that need to be dealt with—and we will continue to implement reforms as that process continues.

Senator O'NEILL: With regard to the interim report that you've mentioned, you're going to receive that next month? Is that correct?

Senator Colbeck: Next week.

Senator O'NEILL: Will it be released?

Senator Colbeck: It will be, by virtue of what it is, yes.

Senator O'NEILL: And your response to that?

Senator Colbeck: What do you mean by 'my response'?

Senator O'NEILL: Will there be a response from the government to that interim report?

Senator Colbeck: We'll consider the report when we receive it. I haven't seen it; so I can't make any comment on what it might be or anything of that nature.

Senator O'NEILL: Are you anticipating responding to the interim report?
Senator Colbeck: It'll depend on what it says.

CHAIR: Senator Roberts.

Senator ROBERTS: Minister, I agree with your comments about the staff in aged-care facilities generally. My mother was in a facility that was an old facility and not modern but the staff were wonderful and she had good care. And my father was in a facility that was brand new and, again, had good care. I want to reiterate that. I agree strongly with the need to ensure that our elders are safe, healthy and respected; so I commend improvements in this area. But looking at the quality standards that you're introducing, I'm concerned, though, about what the commission has done to ensure that the newly introduced aged-care quality and safety standards and audits will not add significant costs to a recipient of aged care in an aged-care facility. In other words, will they be working on the process to make it more efficient and not just adding to the process?

Ms Anderson: Thank you for the question. We don't have any expectation that the introduction of the new Aged Care Quality Standards will add significantly to cost. It is a reorientation of the focus of care. You sound like you may have read the standards. If you haven't, I urge you to have a quick look at them. They're worth reading. There are eight of them and they are very consumer focused. Every single one of them starts with a consumer statement: 'I' something. In fact, I can quote some to you.

What we're asking providers to do is look at their care through the consumers' lens. It's not a vast reorientation or reconstruction of care, it's actually about understanding care through the consumers' experience of that care. Every single one of the eight standards is designed to ensure that that's the lens through which the provider looks and they're working closely with the consumer to come to an understanding of their needs, their goals, their values, their preferences, their identity as a person and then they are delivering care in conjunction with the consumer—jointly planning that care and delivering it in order that they can meet as many of those needs and preferences as possible and deliver the best possible outcomes.

Cost is actually not the issue. It's about mindset, it's about the skill set of the staff and the way in which they're guided in the delivery of care to be always cognisant of the individual to whom they are providing care.

Senator ROBERTS: What I'm hearing is that, instead of it being rule based, it's going to be process and needs based.

Ms Anderson: It's certainly needs based. We, as regulators of that system, look for evidence from a number of quarters. We interview staff, and residents and residents' representatives. We look to the documentation that they might have available and we make observations about the interactions between the staff and the consumers. Through each of those sources, we gather the evidence in order to appraise or assess the quality of that care against those eight standards and the 42 requirements in them.

Senator ROBERTS: So that means then that we won't require valuable nursing staff to be spending more time on paperwork?

Ms Anderson: The allocation of staff to task is a matter for the care home or the service.

Senator ROBERTS: But inherently it's not going to do that?

Ms Anderson: The new standards will not, no. That is not the way they've been designed.
Senator ROBERTS: So we'll have valuable nursing staff giving care rather than completing more forms?

Ms Anderson: That is always our objective.

Senator ROBERTS: Will the cost of the changes to the quality and safety standards contribute to forcing everyday Australians into public aged-care facilities because they can no longer afford it? You're saying, no, they won't.

Ms Anderson: That's not my understanding.

Ms Beauchamp: Can I also add that there's a huge amount of guidance that the commission has put out in terms of meeting the standards, and the government also provided $50 million to providers to help them understand and meet the requirements of the new standards which came into place on 1 July.

Senator ROBERTS: We're just concerned that some people might not be able to afford their own personal care now and might need to go into the government system, which will add more to the government's costs. Thank you very much and I applaud your answer. What is being done to support rural and regional areas where it is very hard to attract and retain skilled aged-care staff?

Mr Hallinan: As part of the discussion we had earlier, we described a 30 per cent uplift in viability supplement and homelessness supplement, which was an ongoing measure to support, in particular, rural providers, Indigenous providers and homelessness providers.

Senator ROBERTS: Can you provide any specific details, or you already have?

Mr Hallinan: Yes, we discussed that in the context of viability.

Senator ROBERTS: I won't take up your time if you've already covered it.

Mr Hallinan: I can get one of my colleagues to come to the table.

Senator ROBERTS: If you've already provided the details before, I don't want to take up the time of the committee with you giving them again.

Mr Hallinan: Yes, we have provided the committee with details on that.

Senator ROBERTS: I'll take your word for it. Thank you. We'll check it ourselves.

Senator WATT: Sticking with the royal commission, testimony was provided last week, in particular, around the implementation of the report by the Aged Care Workforce Strategy Taskforce, the Pollaers report. Last Monday, Professor Pollaers gave evidence to the royal commission in which he said that the government had offered 'no detailed response at all' to his requests for a status update on the task force's reforms to the aged care workforce that were proposed about 18 months ago. Is that correct?

Senator Colbeck: We've started doing some of the things indicated in his report. The Aged Care Workforce Industry Council has commenced, which is in direct response to his report. I'm not sure whether he has been in contact with the department asking for some form of direct response to the report his committee provided. The department might know. I'll ask the department to see if they've had any direct correspondence or requests from him.

Senator WATT: Has there been any detailed response from the department to the recommendations from Professor Pollaers?
Ms Beauchamp: Minister Wyatt at the time, on behalf of government, broadly accepted the findings and the strategic actions of Professor Pollaers. We've been working within government, in terms of the responsibilities across government, for delivery of some of those action areas. The government has also provided an allocation of $2.6 million to assist in the set-up of the new workforce industry council because Professor Pollaers wanted the uplift in workforce qualifications, attitudes and experience to be industry led. So the set-up of the industry council happened with our support, in terms of secretariat support, in May 2019. The Commonwealth also set up an aged-services-industry skills committee in the department of employment to look particularly at vocational education and training and certificates III and IV relevance and curriculum requirements for people working in the aged-care sector. Those are two specific areas where we supported the establishment of that. Professor Pollaers raised a number of other areas where the Commonwealth has taken a leadership role, particularly with interface issues between aged care in the acute setting and primary care. The development of a serious incident response scheme was also mentioned in the Pollaers report, and a range of other matters. So through the royal commission as well we have provided in evidence the department’s response to each of those strategic areas.

Senator WATT: Ms Beauchamp, you were giving evidence on Friday 19 October and counsel assisting was asking you about this response to the Aged Care Workforce Strategy. Obviously you remember giving evidence about this?

Ms Beauchamp: I do.

Senator WATT: Mr Rozen presented to you, as evidence, a brief that had been provided to Minister Wyatt. Do you remember the brief that I'm talking about?

Ms Beauchamp: That was advice from one officer in the department, yes.

Senator WATT: Is that officer around today?

Ms Beauchamp: I'm not sure. I can't recall who that officer was.

Senator WATT: One of the officers who seems to have signed off on this brief was a Mr Speed, who I think you've said is an assistant secretary.

Ms Beauchamp: That’s correct.

Senator WATT: Is he around today? Perhaps he could join us, if he is. Also there was a contact officer, Ms Brown, but more senior people would be here today.

Ms Beauchamp: I went through in absolute detail with senior counsel at the time, so I probably haven't got any further comments to add.

Senator WATT: Sure. But you haven't been at an estimates committee before about this and we would like to ask some questions about it. This brief to the minister, among other things, said that release of a formal response to the Aged Care Workforce Strategy would carry several risks for government. Is that a reason for the government not to release a formal response?
Ms Beauchamp: From my point of view, that was one officer's recommendation to the minister at the time. My discussions with the minister were absolutely to embrace the findings of Professor Pollaers's report and not pre-empt some of the work that was to be undertaken but just to get on with it in terms of our roles and responsibilities in supporting industry in the set-up of the governance arrangements required to deliver those outcomes and strategic areas that were the responsibility of industry.

Senator WATT: But no formal response was provided?

Ms Beauchamp: There wasn't a formal response provided, but the Commonwealth has taken leadership in a number of areas despite the formal written word.

Senator WATT: Could you table a copy of the brief that was being discussed at the royal commission?

Ms Beauchamp: I think that's been submitted in evidence on the website of the royal commission.

Senator WATT: Just for simplicity, I might ask you to table that for us as well.

Ms Beauchamp: I haven't got it here—

Senator WATT: Perhaps you can get someone to do that for us. Mr Speed has joined us at the table. Mr Speed, what were the risks that releasing a formal response to this strategy would carry for government?

Mr Speed: I would need to go back and familiarise myself with the details surrounding that brief.

Senator WATT: I understand that this brief went on to say that providing a formal response would 'invite renewed criticism of the absence of similar responses to other aged-care review concerns' and it would 'lead to renewed attention to 20 sensitive matters such as staff ratios, aged-care funding, access to health services for older Australians and service quality'. Were they some of the risks that releasing a formal response would carry for the government?

Mr Speed: Again, I'd need to familiarise myself with those details.

Senator WATT: Minister, is it appropriate for the government to not release a formal response to an aged-care workforce strategy—a strategy about one of the most important issues in aged care—because it might invite renewed criticism of the government and bring more attention to sensitive matters about aged-care funding and access to health services? Is that a reason to hide something and not respond to it?

Senator Colbeck: My view is that we are responding by actioning and implementing things that were in the Pollaers report. It's difficult to suggest that we're trying to hide anything at this point, given that we've called a royal commission, which is exposing everything. It's difficult for you to make that argument.

Senator WATT: Mr Speed or Ms Beauchamp, do you accept that a departmental brief advising the minister that responding to an aged-care workforce strategy would bring renewed attention to things that the department or the government might not want to talk about in aged care is an admission that the department has failed in other aged-care reviews?
Ms Beauchamp: I don't think it's an admission of that at all. If you look at the context at the time, there was a lot of work going on in terms of establishment of the royal commission. So those issues were already being aired.

Senator WATT: How much money has been spent on these other aged-care reviews that have also had the absence of a similar response?

Ms Beauchamp: Can I clarify: are you asking how much the reviews cost?

Senator WATT: The brief says that releasing a response to this aged-care workforce strategy would invite renewed criticism of the absence of similar responses to other aged-care review concerns. I just wonder how much we've all paid for these other aged-care reviews which the government has decided not to respond to.

Ms Beauchamp: I think the cost of those reviews is on the public record. A formal response was provided in my evidence to both of those reports in February 2019. Not only that, but a number of recommendations have been implemented around the new quality standards, quality indicators, with the work that we're doing around clinical oversight of medication mismanagement in some areas. So a lot is being done in terms of the implementation of those reviews. The government did come out at the time, specifically around the June report, and say what recommendations it was accepting and what ones it probably wasn't, indicating to get on with it and do the rest.

Senator WATT: I might leave it at that for the royal commission. We've got plenty of other aged-care questions.

Senator SIEWERT: Can I follow up on that? Senator Watt has done the workforce strategy stuff fairly comprehensively. I want to know: is the department providing the funding or secretariat support that you articulated earlier to the Aged Care Workforce Council?

Ms Beauchamp: Yes. We have a contract with Miles Morgan to help with the secretariat and set-up and governance of the new council.

Senator SIEWERT: How much is that?

Ms Beauchamp: Off the top of my head, I think it's about $600,000 as part of the $2.6 million.

Senator SIEWERT: Could you take that on notice?

Ms Beauchamp: I've just confirmed that that is correct.

Mr Hallinan: Total committed funding at the moment is $500,000, but there's a budget allocation of $600,000 to go towards the Miles Morgan arrangements.

Senator SIEWERT: I'm sorry? I have trouble hearing sometimes.

Mr Hallinan: The total allocation is $600,000 and the total commitment in work orders so far is $495,000.

Senator SIEWERT: That's what has been done so far?

Mr Hallinan: Yes.

Ms Beauchamp: That's in terms of the secretariat support that you asked about. There is also other funding of the $2.6 million; some of it is being provided through Miles Morgan for other elements in terms of support of the council—for example, development of an online training package, particularly for aged-care providers to help with their leadership and
organisational culture, business skills and the like. I can identify the faces of the 2.6; I might take that on notice.

Senator SIEWERT: Perhaps you could take that on notice. The rural and regional specific strategy: is there funding support for that body as well?

Ms Beauchamp: Which body?

Senator SIEWERT: The team that's doing the rural and regional workforce work.

Ms Beauchamp: Are you talking more broadly about the rural workforce strategy?

Senator SIEWERT: No. I'm talking more about rural and regional aged care; what work is being done there?

Mr Hallinan: The remote accord?

Senator SIEWERT: Yes. I'm sorry; I didn't have the right name.

Mr Smith: Funding support is provided to that. My colleague Mr Barden will be on his way momentarily and he'll be able to provide some detail on that.

Ms Beauchamp: I think we've allocated $1.5 million and have contacted someone to develop up the remote accord; I can't think of the organisation.

Mr Smith: Yes. Uniting Care is leading that.

Senator SIEWERT: I'm aware of that.

Mr Smith: It's bringing together a consortia of rural and remote providers. They've recently brought on board a dedicated officer through the funding that the Australian government has provided. That person started recently and we're expecting to see some outputs from that group fairly soon. There have been a number of meetings. I can get you more specific detail, but I just don't have it in front of me.

Senator SIEWERT: If you could, it would be appreciated; thank you. I would like to ask both the department and the commissioner some questions about physical and chemical restraints. Can I start with you, Ms Anderson? How many complaints have you received in total?

Ms Anderson: Overall, rather than just straight—

Senator SIEWERT: I want to go overall, and then I want to dive down.

Ms Anderson: We've only been in existence for 10 months, but we tend to report in an annual year because we have continuity with the predecessor agency. If I give you a 2018-19 figure, it is six months of our operation and six months of the prior organisation. In 2018-19 we received 7,828 complaints, which was a 35 per cent increase on the prior year.

Senator SIEWERT: Are you able to give me the first quarter for this year?

Ms Anderson: No. I can give you the six months.

Senator SIEWERT: Six months is fine.

Ms Anderson: 4,220—I January to June.

Senator SIEWERT: But you can't tell me—

Ms Anderson: No. I don't have the figures for the first quarter of 2019-20. I can get those for you.

Senator SIEWERT: Can you take that on notice?
Ms Anderson: Yes.

Senator SIEWERT: Thank you. How many of those were around both chemical and physical restraints? I want them separated, not together; I beg your pardon.

Ms Anderson: In 2018-19 we received a total of 122 complaints relating to chemical and physical restraint.

Senator SIEWERT: Related to chemical and physical. Can you break that down?

Ms Anderson: I don't believe I can, I'm sorry. Again, I will try. I'm not sure our search function in our complaints database would allow us to have that granularity, but I'm happy to look at it for you.

Senator SIEWERT: If you could. Can you also tell me why? I realise they are about restraints but they are very different issues.

Ms Anderson: Yes, they are; certainly. Our coding will give us some insight into that. For example, medication management is another angle on chemical restraint. I'm pleased to provide you what we can do.

Senator SIEWERT: That would be appreciated. Again, can I ask you to take that on notice for the quarter because I presume you can't break that down. Was the 122 for the whole of the year?

Ms Anderson: That's correct; 2018-19.

Senator SIEWERT: And for your six months?

Ms Anderson: I'm afraid I don't have this over six months; it is just a single year's figure. Again, I'm probably able to provide that to you subsequently.

Senator SIEWERT: It does seem pretty low compared to what you hear around the traps and other work that's being done. Are you concerned that you're not picking up the use of these restraints?

Ms Anderson: There are a number of reflections to make on that. First of all, the number of complaints we've received has increased substantially over time. In the prior year it was 48. There has been an order of magnitude increase. I agree with you that at face value it does appear a low number. When you put it alongside our work in quality assessment and compliance monitoring, we have a much more complete picture of the use of restraint in aged care. We certainly find we have a number of means of accessing information about the use of physical and chemical restraint in residential care particularly. For example, early this year, in the first several months of this year, we introduced some additional risk screening questions that our quality assessors ask on entry in their opening engagement with the service manager at the home. They will ask, 'Can you please tell me the number of people you are caring for in this facility who are currently the subject of chemical restraint as a proportion of your total resident population?' And then they will ask the same in relation to physical restraint. That is a marker as to whether the quality assessor, in the context of that visit, needs to pay more attention to that compared with the other things that they may need to look at. So on the way in we now have very specific regard for the level of restraint currently in place in that service.

Senator SIEWERT: That leads me to the next obvious question: what have you discovered during that process?

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COMMUNITY AFFAIRS LEGISLATION COMMITTEE
Ms Anderson: It's not a data collection point; it is to assist the quality assessment team on site to ensure that they are looking at the right things as they undertake their visit. We don't actually have a systemised way of capturing that information. However, it does appear in the reports which are produced from the quality assessment team and it is taken into account in the recommendations that team makes and that the delegate considers in reaching a finding or making a decision about the level of compliance for that service with the quality standards.

Senator SIEWERT: How many times have you had a compliance failure against both physical and chemical restraints?

Ms Anderson: They don't appear—well, physical restraint does appear. The 42 requirements under the quality standards don't have that as a specific area which is a pass or fail, but we do have standards which are very specific to allow us to have a close look at the use of restraint. The new standards came into place on 1 July, so most of our data necessarily predates that and, therefore, has been accumulated under the former standards, which were the accreditation standards. The two which are most relevant are behavioural management and medication management. I need to take a step back. When we find failure against an expected outcome under the old standards, or a requirement under the new standards, we are then also required to consider whether one or a number of residents may be or is at risk of harm to their safety, health or wellbeing. So we find noncompliance and then we consider whether there's a finding of serious risk that we also need to make. Typically, there are findings of serious risk which also pertain to behavioural management. If there's inappropriate or unauthorised use of restraint, that would typically qualify as evidence that would lead a decision-maker to make a finding of serious risk.

We made a number of serious risk decisions in relation to the behavioural management expected outcome under the accreditation standards. In January to June 2019—our first six months of operation—we made serious-risk decisions on 43 occasions. We made decisions about failure to meet that particular standard—which happens to be standard 2.13—on 94 occasions. So non-compliance decisions on 94 occasions and serious risk decisions on 43 occasions aligned with that 94.

Senator SIEWERT: Which related to both behavioural management—

Ms Anderson: No. Medication management is separate. Again, going through the same process, decisions regarding failure to meet the expected outcome—which is 2.7—about medication management, 57 in total; and then 15 serious risks consequent upon the finding of noncompliance.

Senator SIEWERT: 57 and 15?

Ms Anderson: Yes, 15.

Senator SIEWERT: In terms of the complaints that you received—

Senator HUGHES: Sorry, can I just interrupt, Senator Siewert, before we move off restraints? Are you still on restraints?

Senator SIEWERT: Yes, but you go.

Senator HUGHES: With the medication management and some of those actions that are underway, could you give us more detail of what's occurring with regards to medication
management and other actions that you've undertaken and particularly the importance of the
new requirements on restraints?

**Ms Beauchamp:** It is worth going through that in a number of areas around (1) the quality
standards, (2) the regulatory approaches and (3) the non-regulatory approaches. I will defer to
Professor Murphy, particularly around the aged-care clinical advisory committee and the
work that's being done on that. I think the standards which came into effect on 1 July do
absolutely contain requirements to contain the use of restrictive practices. I think it absolutely
strengthens the provider's obligations in relation to clinical care. There is a requirement to
work with care recipients and families in the development of care plans. Medication is part of
that and, obviously, any therapeutic requirements around the use of what's been referred to as
chemical restraints as well. As to the restraint around the quality indicator from 1 July 2019, I
think we've mandated the collection of data, particularly around physical restraint. We're
working on looking at a similar indicator around medication management as well. I think the
non-regulatory approach is probably important to refer to because there have been other parts
of the organisation that have been looking at restricting practices and the use of risperidone,
for example, and we're doing some work in terms of, I guess, restraining the use of
medication management. I might ask the professor to talk about some of the work that he's
doing on the clinical committee.

**Prof. Murphy:** The clinical advisory committee, which I chair, has been meeting
throughout this year. It's very important to take a complex, holistic view of this issue. There's
been some interesting debate that all psychotropic drugs should be banned, debate of that sort
of nature. These drugs actually have a valuable purpose in a small portion of people with
psychotic dementia. They are important to prevent self-harm. But clearly there is overuse and
we've acknowledged that at this—

**Senator SIEWERT:** Where's therapeutic? I don't think anyone has acknowledged that.

**Prof. Murphy:** I know. Every use of psychotropic or antipsychotic drugs is not chemical
restraint. There is a therapeutic purpose, but in a range of strategies—many of them
regulatory, which Mr Hallinan and his team can talk about—we are doing a lot of work to
engage particularly the GPs who are visiting those aged-care facilities to educate them. Most
of the GPs who prescribe these drugs are not doing so with some evil intent to restrain
someone. They believe that they are prescribing a therapeutic drug. The trouble is that when
you're prescribing it in a situation just for behavioural management of dementia, it's not
appropriate and it is harmful. We know that. We are working very closely with the two
colleges, with a range of expert psychiatrists and geriatricians, and we are doing a range of
educative proposals and regulatory moves to try to put in barriers and education to try and
stop it. We are obviously trying to enforce with the GPs the requirement that starting a drug
like this is a material clinical intervention which requires them, as a duty of care as a medical
practitioner, to obtain informed consent from generally the substitute decision-maker—
because these people are not usually competent—and that they have that very strong duty of
care. They need to inform the relatives and discuss it with them. There needs to be a clinical
governance process around it and, most particularly, the crucial thing with these drugs is that,
if they are trialled, and there are legitimate circumstances where they need to be trialled, they
are reviewed, tapered and stopped where possible. It's only in very rare circumstances where
long-term use is justified. We have about 10 different strategies that we are pursuing. Dr
Towler is leading the implementation of those. It's not just regulatory. It's very much a clinical governance, clinical culture approach. Mr Hallinan might want to add to that.

**Mr Hallinan:** Certainly. With the restraint principles and regulations that have been put in place, it is definitely worth contemplating them outside just that regulation that's currently subject to discussion in this place. First off, outside of that regulation, we've put the use of these medications to the Pharmaceutical Benefits Advisory Committee and government assessment for further controls and restrictions on prescribing the medications. At the moment there is an authority required for the first 12-week period and PBAC has recommended a second authority be provided for any prescribing beyond that period. The reason we think that is important goes to who is actually in charge of the medication itself that's used in the circumstances. It is not the aged-care provider. They don't prescribe and they have no role in the prescribing. They do have clinical governance frameworks and regulation in the aged-care sector that they need to work to, but there is a co-regulatory environment through health practitioners and that goes to the dispensation of medication. PBAC has recommended new authority arrangements for risperidone in particular.

**Senator SIEWERT:** I was going to follow that up when we see PBAC.

**Mr Hallinan:** We will also be targeting letters to prescribers as well, so those who have high rates of prescribing of medications—benzodiazepines and antipsychotics—in the sector. We will be able to provide educative processes to them. We're working with the colleges and others. I might ask Dr Towler to provide some examples of this on education products throughout the sector for prescribers. I will hand off to my colleagues.

**Dr Towler:** As my colleagues have outlined, we have a suite of programs and projects in place that are directly around trying to address this issue of inappropriate use of these medications, psychotropics—primarily antipsychotics and benzodiazepines. In the education area there are a number of products out there and some really high quality products targeting a diversity of audiences, from families, who can be really important advocates for their loved ones in facilities, through to people who work in those environments, through to clinicians, doctors, nurses and nurse practitioners, and pharmacists. So there are already products there. With the assistance of a consultancy that is currently underway, we are looking at those, the quality of those, and at how we can repurpose them. We are thinking to ourselves that some of these are really high quality, so why haven't they hit the mark? Why do we still have that problem? We are looking at not just the quality and nature but the formats of delivery and the ways in which we provide those products, to make them more effective. As my colleagues say, it's an integrated range of projects that are working with the colleges, working with GPs, particularly GPs who work and have a lot of expertise in aged care—so they are guiding us as we go—the geriatricians and the psycho-geriatricians.

**Senator SIEWERT:** I have a series of questions that I will end up putting on notice. One of my overriding questions is—and thank you for the information you've provided—for example, physical and chemical restraints are being used on a lot of people with dementia because the residential facilities are not properly designed; they are not properly implementing cognitive behaviour practices. When do we get to the point where we require residential providers to actually provide facilities that are properly designed to address residents with dementia, which we know is only going to increase? I have seen best practice. I
know it's possible, and it doesn't cost the earth. When are we going to get to that point? Minister, it might be something for you.

**Senator Colbeck:** It's a good question, and it's clearly something that's a point of discussion at the commission. The government's clear perspective by the implementation of the new regulations—and not just putting the regulations there and leaving them—as you have heard, is that there is a range of things happening in conjunction with it. Commissioner Anderson is also doing some work in the way that she assesses—which comes also to your point—the quality standards, because all these things play into those broader processes. It's about trying to drive behaviour change from the sector. There is a significant piece of work that's been done on transferring some of that best practice through the industry—some of the programs we have running, for example, with Dementia Australia—what is about addressing understanding of behaviours, what people with dementia actually see, why they react in certain ways, and transmitting that information across the sector so that we can start to drive that change. You've got in excess of 50 per cent of the residential aged-care population with some form of presentation of dementia. In my view, it has to become part of everyday practice. There is a significant piece of work to do for the whole sector in changing that practice. This is the commencement of that process.

We've had some conversations around workforce. There is a significant piece of work, I think, in uplifting capacity in the workforce. Some of the measures we have in place are about addressing that. There is some fantastic work that is already out there. I refer to the Wicking institute at the University of Tasmania and the MOOCs that they have, which are free. There are two of those. They are about to run them again. I've spoken to aged-care workers who have done them more than once because they think they're so good.

There is a lot of work to do in changing behaviour in this sector. I note your comments about the number of complaints and your perception about where they might be or where they should be. There is clearly work to do in that space. The government's view is that those things need to move. The introduction of the new regulations is part of the process, but it's not just about putting the regulations there and expecting people to comply with them; it's actually about doing the other things through the other instruments we have that start to change that behaviour.

**Ms Beauchamp:** This is a particularly important area for us in the department, too. We are looking at 50 per cent of people in residential aged-care facilities having dementia, and we need to look at each individual. I agree with you; there are some fantastic models out there, but it's probably worth going through some of the training programs that we are doing.

**Senator SIEWERT:** We don't have time now. If you could take that on notice—

**Ms Beauchamp:** We are also doing dementia-specific services. In terms of the care models, there is a lot that the NHMRC, and indeed the funding through the Medical Research Future Fund, are doing. The $185 million is actually looking at what is best practice and what care models we should be looking at in the future for people suffering with dementia.

**Senator SIEWERT:** But it's not being done?

**Ms Beauchamp:** I'm saying there is $50 million a year, for example, going into training. We have an arrangement with Dementia Australia in terms of the services. We have our clinical teams, both the severe and less severe teams, that can be accessed by residential aged-
care providers, in addition to the training that's going on, plus the research around the care model. I don't want to leave you with the impression that it's not an important priority. Indeed it's not a one-size-fits-all. There are some fantastic care models out there, but we are doing a lot.

Senator SIEWERT: We are still seeing a lot of restraints used, however. I appreciate everything you've said but it's obviously not addressing the issue fully yet.

Senator Colbeck: The new regulations have been in place since 1 July.

Senator SIEWERT: That's why I want complaint information.

Senator Colbeck: We have had some very constructive conversations—and I'm happy to continue those—around this process, because it is a very important part of care.

Senator SIEWERT: You may need to take this on notice: one of the issues that I'm deeply concerned about that I don't think we are addressing property is sexual abuse in aged-care facilities. I'm wondering, Ms Anderson, how many complaints you've had on that particular issue, and are you specifically addressing that particular issue?

Ms Anderson: There are a number of parts to my answer. Some of them I will refer to the department because it goes to the compulsory reporting requirement placed on services in instances of assault. There are obligations that the providers must fulfil, including reporting to the department and the police. We share your concern. We believe that this is an area which requires closer attention and we are in discussions with the department about that. The Serious Incident Response Scheme, which is a reform well underway, is a very direct approach to ensuring that the regulator has greater visibility of instances of assault in aged-care services environments and that we are fully confident that the services are doing what they need to do, not just to address the incident itself but to ensure that they have in place appropriate processes, rosters, degrees of oversight, supervision, training et cetera to ensure residents and consumers of care are appropriately protected at all times.

Senator SIEWERT: Are you confident that they have those provisions in place now?

Ms Anderson: I believe it is a work in progress. We continue to receive reports through the compulsory reporting process which suggest that there remains an incidence of assaults in services which still needs to be attended to. In the same way that you've identified restraint as an area of ongoing attention, and we absolutely agree, this is as well.

Senator Colbeck: In respect of the toolkit that the commissioner has, I've written to the Aged Care Quality and Safety Advisory Council some weeks ago asking them to look at what tools might be required by the commissioner to deal with a range of issues across the work that the commission does. I should have some information back on that very soon. I've spoken to the chair of the advisory committee. I wrote to them about three or four weeks ago, asking what additional tools were needed, bearing in mind that there is a process of legislation that is about to go through the parliament, hopefully prior to Christmas, to finalise the structure of the commission. It's about what else might be required. I have written asking the advisory committee to give me some advice on that.

Senator O'NEILL: I have a few questions about the reviews that have been discussed earlier, with regard to how many reviews have been held. After two years how many of the 43 recommendations of the Australian Law Reform Commission's report on elder abuse have been fully implemented?
Senator Colbeck: You will have to speak to the Attorney-General's Department about that.

Senator O'NEILL: No responsibility for that here?

Senator Colbeck: They are the lead agency that is looking at the elder abuse reforms. The Law Reform Commission reported to the Attorney-General's Department. Our department is working in conjunction with the Attorney-General's Department, but they are the lead agency.

Senator O'NEILL: Could you take on notice how many of the 43 recommendations that are relevant to the department have actually been implemented?

Ms Beauchamp: We can take that on notice.

Senator O'NEILL: And give evidence of where that's occurred and the funding allocations.

Ms Beauchamp: Sure.

Senator O'NEILL: There is a theme here. The next one is the Tune review. I have a copy of it here. There were 38 recommendations, including several that I think are very important, that we will get to shortly, with regard to home care packages. How many of the 38 recommendations from the Tune review have been fully implemented?

Senator Colbeck: Not all because the government didn't agree with all of them. There were a couple specifically that we said that we didn't agree with; I think it was 13 and 15 that we said we didn't support. Progressively, we are implementing a number of reforms that will address some of the issues that were raised in the Tune review.

Senator O'NEILL: Twenty-five, you assert, are implemented of the 38?

Senator Colbeck: No, I didn't say that. I said we are working through a range of reforms across the sector that will address some of the issues that were raised by the Tune review.

Senator O'NEILL: Could you provide a detailed summary of the 25 that you say are underway, what stage of implementation they are at, what plans are aligned to the 25 that you are implementing and the cost allocation for implementation for each of those?

Ms Beauchamp: I haven't got that detail in front of me; certainly, we can get that. We have been quite active in terms of implementing recommendations.

Senator O'NEILL: There is concern about how many recommendations have been made and the failure of implementation of those. Can I go to the response that you gave to a question from Senator Polley—who I note has joined us—with regard to the Carnell-Paterson report, which has been the subject of some discussion this morning? You stated that all 10 of the recommendations of the review have been adopted in whole or part by the government. The reason I'm referring to your response to question SQ18-858 is that Professor Paterson himself, at the royal commission on 7 August this year—he was the co-author of the Carnell-Paterson review—said that the government's progress on implementing the recommendations of this report was disappointing. That was his characterisation:

I'm disappointed, however, to learn of the slowness in implementation of the recommendations and I am left with a sense that the 10 recommendations have all been accepted in principle but the devil is in the detail and I can't help suspecting that some of them are not actually being progressed.
Given that it's now two years since the review was made public and the response is there from Professor Paterson, can the department confirm how many of the 10 recommendations have been fully implemented? That is not evident in your response.

Mr Hallinan: I can talk you through the 10 recommendations and where we're at on each of them, if it would assist.

Senator O'NEILL: Have you got a document that you can table there?

Mr Hallinan: I can table a document on that.

Senator O'NEILL: Thank you; that would be helpful. I might come back to that after I've had a chance to read it. You indicated in your response that there were some funding allocations under three criteria, but I am interested in full implementation.

Mr Hallinan: We don't have funding identified against each recommendation but we do have an update on what we've done on each.

Senator O'NEILL: Great; thank you. After a year, how many of the 14 measures included in A matter of care, the workforce strategy, have been fully implemented?

Ms Beauchamp: As I gave in evidence at the royal commission, many of those recommendations were to be industry led. We have provided detailed responses to each of those strategic actions. I can reproduce that for the committee, if you would like. It's actually public and on the royal commission's website.

Senator O'NEILL: If you could table that, if somebody could assist us by getting it to us—

Ms Beauchamp: It is publicly available on their website.

Senator O'NEILL: I know, Ms Beauchamp. It's just a matter of sitting still, and going and finding it. If it can be provided by the department, that would be very helpful—

Ms Beauchamp: I can provide the link.

Senator O'NEILL: rather than having to chase it. Thank you very much. How much funding has been allocated to the Aged Care Workforce Industry Council to date to progress the 14 measures in the workforce strategy?

Ms Beauchamp: I think we covered that earlier in terms of the total, around $2.6 million, and exactly what we've spent in terms of the Miles Morgan secretariat support.

Senator O'NEILL: Of the $2 million that remains, you indicated the secretariat support was $600,000, of which $500,000 has been expended. Is that correct? How much of that funding will be allocated to the ACWIC to undertake the work to progress those 14 measures?

Mr Hallinan: There is $2.62 million as part of that package. There is $1.2 million that goes to logistical and support services for the Aged Care Workforce Industry Council, made up of around $600,000 for the secretariat through Miles Morgan; around $600,000 for an evaluation framework for the strategy to be led by the council.

Senator O'NEILL: Sorry, Mr Hallinan, could you speak a little more loudly? I'm having trouble hearing you as well.

Mr Hallinan: Then we have $660,000 for the development and delivery of tailored online training modules for aged-care managers; and around $760,000 to develop options to better integrate health and aged-care workforces. How do you manage the health and aged-care
workforce integration between doctors, nurses, allied health providers in and out of aged-care settings?

Senator O'NEILL: Thank you for breaking that down into those four areas. Do you have a document that aligns them against the 14 measures?

Ms Beauchamp: I refer to the evidence that's been given to the royal commission.

Senator O'NEILL: That does that?

Ms Beauchamp: Yes, but some of those are the responsibility of industry in terms of codes of conduct and the like. We could provide a more detailed response in terms of what the Commonwealth is doing under each of the measures.

Senator O'NEILL: Thank you. I would appreciate that on notice. A final line of questions, if I could around ACAT: are the right people at the table? How many ACAT assessments have been undertaken in the past 12 months—that is, 2018-19?

Dr Hartland: Just bear with me for a second.

Senator O'NEILL: An annual and quarterly breakdown as well, if possible.

Dr Hartland: I can certainly find the annual breakdown for you quite quickly. In 2018-19 there were 178,363 assessments that were completed and 125,933 support plan reviews.

Senator O'NEILL: I've got some other questions here. It would be great if you could provide it annually and in a quarterly breakdown. I'll put the remainder of those on notice, in the interests of time. Thank you for coming forward, Dr Hartland. Are we ready to move onto another line of questioning?

Senator WATT: I have just got a few questions about home care packages. Do we need anyone else to join us?

Ms Beauchamp: Yes, we do.

Senator WATT: I want to get some baseline figures, to begin with. We've previously obtained figures from the department about the number of older Australians who have died while waiting for home care packages. We've had those figures for 2017-18 in the past. Are we able to get figures for 2018-19?

Dr Hartland: Not at this point. We are refreshing those figures but we don't have updated figures for you.

Senator WATT: We don't actually know the number who have died at this point?

Dr Hartland: We don't. We are doing that analysis at the moment.

Senator WATT: Do we know anything about the level—whether there are more people waiting for level three or four packages rather than one or two?

Dr Hartland: We've provided—I believe, in response to a question on notice—some information about that for previous years, and when we do the analysis we will have it in the same form. But we don't have updated figures at this point.

Senator O'NEILL: When do you expect to be able to provide that?

Dr Hartland: It is certainly close. I would think within the month.

Senator WATT: I might get you to take that on notice.

Dr Hartland: Of course we will take it on notice.
Senator WATT: But the most recent figures we have, for 2017-18, were that 16,076 older Australians died while waiting for a home package which they had been approved for. Is that correct?

Dr Hartland: The 16,000 figure refers to people who are in the national priority system. I think there is a debate about what their intentions are. Some of them might be not seeking a home care package; they might be seeking residential care. But the 16,000 people who were on the national priority system without having a package allocated to them—

Senator WATT: Was 16,076.

Dr Hartland: Sorry, I need to correct myself. I am looking at the question on notice. I should have read it in more detail. Some of those people would have an interim package and some of those people would have a CHSP service offer.

Senator WATT: Some of these people might have had an interim package, which is another way of saying a lower level of support and care than what they were approved for, and then there are others who had no package at all?

Dr Hartland: Yes. There would be some who don't have a package that they are using, and many of them will have a CHSP service offer.

Senator WATT: Do we have any figures, current figures, for 2018-19 of the number of older Australians who have entered residential aged care while waiting for the home care package they have been approved for? That's for 2018-19.

Dr Hartland: No, I don't believe we could give you an accurate figure of that. Many people who are going into residential aged care will typically get an approval for residential care as well as home care.

Senator WATT: The reason I'm asking for 2018-19 figures is that again Senator Polley had a question on notice, No. 336, from budget estimates this year where we did get figures from you saying that for 2017-18, in addition to the 16,076 people approved for home care packages who passed away, there were an additional 13,430 people who were approved for home care packages but entered residential care because they were unable to get their home care package. I'm really just seeking an update of that figure.

Senator Colbeck: Is it a matter that they entered the home care because they couldn't get it or they might have had it approved—or both?

Senator WATT: I'm just going off the figures you have given.

Senator Colbeck: It's an important distinction to make. As the officer said, some people get an approval for both and they go to one or the other.

Senator WATT: Yes, but they go to residential care because their needs have got to such a point that home care can't deal with them, because they've been waiting so long for a home care package.

Dr Hartland: That is the assumption we don't have data on. We can tell you how many people left the NPS to go to residential care, but whether that was because they didn't get the package that they were assessed for in the time that they wanted or because they actually wanted to go to residential care, which is the point the minister is making, we can't give you data on that.
Senator WATT: Can you take it on notice? What I'm looking for are the 2018-19 figures that match up with that 13,430 figure for 2017-18.

Dr Hartland: Yes, we'll take it on notice.

Senator WATT: Does the department have any details about the number of older Australians who have been waiting for their approved home care package and who have entered the hospital system in 2018-19?

Dr Hartland: No, I don't believe I have seen that figure. We've in the past calculated figures of people who have entered the hospital system from residential care, because that's an issue that is often raised with the states and we discuss it with them, but I don't believe I've seen that figure. We would have to test whether it would be something we could analyse.

Mr Hallinan: I'd be surprised if we could actually get that number.

Senator WATT: Could you take that on notice for us?

Mr Hallinan: We will look into it.

Ms Beauchamp: Assuming people accessing the hospital system are accessing it for medical and clinical care.

Senator WATT: Presumably. I don't think it's a great leap of logic to say that that is in some way due to the fact that they haven't been able to get the home care package that they've been approved for.

Ms Beauchamp: I wouldn't jump to that correlation at all.

Senator Colbeck: I think that's a bit like the correlation you tried to make between people who might have an allocation for both an aged-care package and a home care package. You might want to make that for your own purposes and that's fine. You do that, but it's a bit of a leap of faith.

Senator WATT: Are you saying that there are no instances where—

Senator Colbeck: I'm not saying that at all, but I'm just not making a broad assertion, that's all. That's the point that I make.

Senator WATT: It's reasonable to assume that there are a range of people who are waiting for a home care package they've been approved for, in some cases for more than two years, and their health gets to such a point that they have to go to hospital.

Senator Colbeck: There may be some. I'm happy to accept that there may be some. I'm not going to make a broad assertion. That's all.

Senator O'NEILL: Isn't it important for you to know that number though, for planning purposes?

Senator Colbeck: The question is—

Senator O'NEILL: It seems like there's a bit of data poverty here that's severely going to impact policy making.

Senator Colbeck: The question is: is it possible to gather that data? That's the question the officers are asking. They've said they are prepared to take the question on notice, which is fine.
Ms Beauchamp: The other element is the episodic nature of people going into hospital for good clinical reasons. And you're looking at a home care package or a residential care package for longer term. People are going into hospital generally for a short-term episodic need. I think it is two different questions.

Senator O'NEILL: Do they? That is an assertion that perhaps cannot be made without the data. That's just the point. It's very difficult to make policy without accurate data.

Ms Beauchamp: We might be able to provide information on why people of a certain age are going into hospital.

Senator WATT: Just back to the point about the number of people who have died while waiting for a home care package when they've been approved, you've obviously taken on notice an annual figure for 2018-19. Do you have any more recent figures than those figures for 2017-18, whether they be—

Dr Hartland: No, we don't.

Senator WATT: For a particular month? A six-month basis?

Dr Hartland: No, we don't.

Senator WATT: You're saying you're about a month away from being able to tell us the entire year.

Dr Hartland: We are a month away from calculating the annual figure. The approach we've taken with this issue is to calculate an annual figure for you, because the Senate's interested in it. And we are close to being able to provide an updated annual figure.

Senator WATT: If you're close to being able to provide an annual figure, you must know, or there must be officers—whether they be here or back at the office—who have the figures for last July, August, September, maybe up to 31 December?

Dr Hartland: No. That's not the approach we've taken to analysing these figures.

Senator WATT: I'm asking you—

Dr Hartland: In a regular cycle we look back and say, 'What happened over the last year in terms of people on the NPS in relation to whether they exited because they passed away or they went into residential care?'

Senator WATT: This might not be the approach you've taken in the past but we've got every right to ask you for figures on any basis—whether it be monthly, six-monthly, 12-monthly.

Dr Hartland: I'm not saying that you don't have the right to ask. I'm saying we haven't done it.

Senator WATT: You're a month away from telling us an annual figure and you can't tell us numbers for July or August or September or up to the 31st of this month?

Ms Beauchamp: I will take that on notice and see what we can get.

Senator WATT: Can you have a look at that over the lunch break, please?

Ms Beauchamp: I will see what's available.

Senator WATT: Working just on the figures we've got at the moment—and minister, it's on the public record that in the most recent report of the government, as at the 30 June this
year, there were just short of 120,000 older Australians still on the waiting list for a home care package.

Senator Colbeck: At the level that they were assessed.

Senator WATT: At the level they were assessed. They've been approved for a home care package at a particular level, and there are about 120,000 of them still waiting for the package they have been approved for. Minister, is it acceptable that that many people have to wait that long?

Senator Colbeck: I will make a couple of points. Most of them have access to some form of care.

Senator WATT: No, that's actually not true. There are 47,462, which is fewer than half—not most, fewer than half—who have an interim package, which means they get a level of care below the level they've been assessed as needing.

Dr Hartland: I actually don't think 95 per cent have access to CHSP.

Senator WATT: But it's hardly a home care package, is it? They might get some form of support. But we're talking about home care packages here. There are about 120,000 older Australians who have been approved for a particular home care package. They're not getting that package. They are on the waiting list. And there are 72,000 of them who don't have any home care package at all. They might get other support, minimal support, but they're not getting any home care package, let alone the one they've been assessed as needing.

Senator Colbeck: They do have access to some support. I think that's an important point to make—they aren't being left without any support at all. Is the number too high? Yes it is. That's why we've continued to invest in that sector. Since last year's budget we have put $2.2 billion into it. An extra 25,000 places came on stream last financial year. We continue to grow that sector. It's an important part of the provision of care to senior Australians.

Senator WATT: You've been in power for six or seven years. Quite apart from anything the royal commission had to say about the Commonwealth being missing in action, is that why we've now got around 120,000 older Australians waiting for a home care package which they've been assessed as needing?

Senator Colbeck: We've more than doubled the number of home care packages since we came to government.

Senator WATT: And you still have 120,000 people waiting!

Senator Colbeck: Senator, if you want to make that point, you went to the last election with—

Senator WATT: Mate, you won the election—get over it! You are in government. You have been in government for seven years. Take responsibility.

Senator Colbeck: You went to the last election with $387 billion worth of new taxes and not one dollar for an extra home care package, so don't lecture us. You went to the election with $380 billion worth of new taxes, and not one dollar for an extra home care package. We put $2.2 billion in the last budget—

Senator WATT: You have 16,000 people dying while waiting for a home care package.

CHAIR: Senator Watt! Senator Smith has a question as well.
Senator DEAN SMITH: As a result of all those interjections I didn't hear the answer the minister gave. Could you repeat that for my benefit, Minister Colbeck. You mentioned that a point of contrast was that Labor didn't have any—

Senator WATT: They went to the last election—

CHAIR: Senator Watt!

Senator WATT: with $187 billion worth of taxes and they did not give one dollar to—

CHAIR: Senator Watt, please let us hear the answer.

Senator DEAN SMITH: When Labor had the eyes of the country on them and on their aged-care policy, when the whole country was looking at them in April and May and forming a view, Labor did not put one red cent into extra funding for home care packages.

Senator Colbeck: That is correct.

Senator WATT: Are you the minister for aged care?

CHAIR: Please direct the question through the chair, Senator.

Senator Colbeck: Senator, that is an obvious response.

Senator WATT: You are. Are you in government?

Senator Colbeck: I've made a number of responses to you in respect of where the trajectory needs to go on this, and I've been very open and public about it.

Senator WATT: My question is: are you in government? Either you are or you aren't.

Senator Colbeck: What I won't cop is political criticism from the opposition when they had the opportunity to do something substantial about this.

Senator WATT: It's not just the opposition making this point; it's every person who contacts my office—

Senator Colbeck: The scenario would not have been different today.

Senator WATT: about waiting for a home care package for their mother, father, or grandparent. That's who is complaining about this; it's not Labor.

Senator DEAN SMITH: And in May you cared so much that you did not give one red cent.

Senator Colbeck: If you listened to my answers earlier around reflections on where the numbers need to go, you would be clear on the government's views.

Senator WATT: It's not acceptable for 120,000 older Australians to still be waiting for their home care package.

Senator Colbeck: Our objective is to reduce the number of people who are waiting. The number on the waiting list dropped for the first time during the last quarter of reporting.

Senator O'NEILL: That is cold comfort to those who are continuing to wait.

Senator Colbeck: Senator, if you're going to criticise me, put your money where your mouth is when it counts—when people are voting for you.

Senator O'NEILL: When I'm in government, absolutely, but the reality is you're the government—

CHAIR: Senator O'Neill!
Senator Colbeck: Why didn't you do it at the election? You had the chance and you did nothing.

Senator O'NEILL: People are just trying to get a decent care package and you are ignoring them and giving us this political nonsense. It's a disgrace!

CHAIR: Senator O'Neill!

Senator Colbeck: You went to the election with $387 billion in taxes—

Senator O'NEILL: There are 120,000 people waiting—

Senator Colbeck: and not a red cent for home care.

Senator O'NEILL: and 16,000 people died and no figures for us to find out about how many more—

CHAIR: Senator O'Neill!

Senator DEAN SMITH: Senator O'Neill has absolutely mischaracterised the matter—

CHAIR: Could we please refrain from being so rude and disrespectful to each other?

Senator WATT: Hearing what you are saying, you do agree that it's not acceptable that 120,000 older Australians are waiting for the home care package that they have been assessed for?

Senator Colbeck: We continue to invest in home care packages. The trajectory of growth is clear and has been articulated a number of times, growing out to 157,000 based on the current investment. Would I like to see the number of people receiving a home care package increase? Yes, I would.

Senator WATT: Is it acceptable that some older Australians have to wait more than two years for their approved home care package?

Senator Colbeck: I would like to see the time for people waiting for residential home care packages reduce. That is the government's desire as well.

Senator WATT: You might be able to do something about that. You are the minister.

Senator O'NEILL: Chair—

CHAIR: Please let the minister answer.

Senator WATT: You would like to see something happen. Then why don't you do something?

Senator O'NEILL: If you had the desire!

CHAIR: Senator O'Neill!

Senator Colbeck: Senator O'Neill, why didn't you do it when you had the chance?

Senator O'NEILL: We're not in government, mate!

Senator Colbeck: When you were asking to be in government you didn't do a thing.

Senator O'NEILL: You can talk about 'desire' all you like. We're talking about people who are dying; that's the 'd' word—not 'desire'.

Senator Colbeck: How can anyone believe anything you say? They can't. You had the chance.

Senator O'NEILL: If we had government, it would be a very different situation.
Senator Colbeck: When you had the chance to do something, when people were making up their minds, you did nothing.

CHAIR: Order! Return to the questions, please.

Senator WATT: Minister, is it acceptable that someone aged 95 years of age has to wait more than two years to get a home care package?

Senator Colbeck: As I said to you, Senator, I would like to see the waiting time for home care packages reduced.

Senator WATT: Are you intending to do anything about this? You are the minister for aged care. There is no-one in the country who can do more about this. You're telling us what you'd like to see: you'd like to see this; you'd like to see that.

Senator Colbeck: As I've indicated, we put $2.2 billion in last year's budget to increase the number of home care packages. We have more than doubled them since we came to government; that trajectory goes out to 157,000.

Senator O'NEILL: Is that enough?

Senator Colbeck: When the Labor Party had the opportunity at the point of decision—

Senator WATT: The electorate voted for you. It's over. You won. We know that. You're in power.

Senator Colbeck: When you had the opportunity to make a difference, you didn't.

CHAIR: Senator Hughes has a question.

Senator HUGHES: Minister Colbeck, I noticed that in 2012-13 there were only 60,308 home care packages. The figure that you've given now—

Senator WATT: How many years do you have to be in power before you take responsibility?

Senator HUGHES: is that there are 157,154 home care packages. So that would be an increase of 161 per cent.

Senator WATT: Are you aware that the population is ageing?

Senator HUGHES: Aside from the fact that we are assisting 96,846 more people with home care packages, perhaps you can give us an update on the funding increases we've seen due to the growth in high-level packages.

Senator O'NEILL: It is not enough.

Senator Colbeck: It is a lot more than you were offering.

Senator HUGHES: It is a lot more than you were offering.

Senator Colbeck: The funding for home care packages in 2012-13 was $1.5 billion; in 2019-20 it will be 3.368 billion.

Senator WATT: You might like to tell us what the waiting lists were in those years as well.

Senator Colbeck: Senator, you didn't tell us.

Senator WATT: They're a lot longer.

Senator Colbeck: You hid it.
Senator HUGHES: Excellent question!
Senator Colbeck: You hid the waiting list. You wouldn't tell anyone there was a waiting list. We have actually provided information—
Senator WATT: That's right. We couldn't get access to that.
Senator Colbeck: You didn't tell us what the waiting list was.
Senator WATT: It's pretty sad that after so many years in power—
CHAIR: Senator Watt, please let the minister answer the question!
Senator WATT: all you can do is talk about what happened seven years ago.
Senator Colbeck: You didn't tell us—
Senator WATT: You are that embarrassed—
CHAIR: Senator Watt, please let him answer the question.
Senator Colbeck: In 2020-21 the number will be $3.62 billion; in 2021-22 it will be $3.78 billion, and in 2022-23 it will be $3.78 billion.
Senator WATT: Is it acceptable that, on the most recent figures, about 16,000 older Australians have died while they were waiting for their approved home care package? Does it get much worse than that?
Senator DEAN SMITH: That is a gross—
Senator WATT: It's the truth.
Senator DEAN SMITH: The characterisation you are putting over that, Senator Watt, is a gross—
Senator WATT: Let's put it in a clinical way. Question on notice: the number of clients who exited the NPS with a reason of 'deceased' in 2017-18—nice empathy—totalled 16,076. So 16,076 older Australians have died while waiting to get a home care package that they have been assessed as needing.
Senator DEAN SMITH: A more honest question might have been to ask the ages of those people.
Senator WATT: They are older. They are aged. Of course they are older people.
CHAIR: Let the minister answer the question.
Senator WATT: So it's their fault that they were old and died? Is that acceptable, Minister?
Senator Colbeck: I wouldn't characterise a cause and effect to those numbers.
Senator WATT: Do you understand how heartless that sounds?
Senator Colbeck: Senator, I am not trying—
Senator WATT: You have 16,000 people dying and you want to talk about cause and effect?
Senator Colbeck: Senator, let me finish my answer: we would like to see those numbers reduced. We would like to see people get access to their home care packages as soon as possible.
Senator O'NEILL: You are the government. You could do something about that.
Senator Colbeck: I’m not trying to be hard in any way, but I don’t accept the characterisation you put that there is a cause and effect—

Senator WATT: Isn’t the truth of all this that your government is so obsessed with reaching a surplus that it’s prepared to let older Australians die while they are waiting for home care packages—6,000 of them a year?

Senator Colbeck: I do not accept that characterisation.

Senator WATT: If you were prepared to do something about this waiting list that you have presided over for six or seven years, we could deal with this problem. But you and your government have made the decision that it’s more important to rack up a surplus than to care for the older Australians who voted for you.

Senator Colbeck: I do not accept that characterisation, Senator Watt.

Senator WATT: But you are prioritising a surplus over this. You could fix it with more money, but you have chosen to prioritise a surplus.

Senator Colbeck: You can make all the assertions you like, Senator Watt. I do not accept your characterisation.

Senator O’NEILL: Senator Colbeck, you keep using the word ‘desire’. My question to you is: why would you desire a situation that allows this gross neglect of older people to continue?

Senator Colbeck: Again, I reject your characterisation, Senator O’Neill. We are looking to provide older Australians with the services they need when they need them. That is our objective. That is why we are continuing to grow the number of home care packages. That’s why we have made the investment and that’s why we criticise the Opposition for not making any investment.

Senator O’NEILL: What is preventing you from addressing the waitlist in full? You know the size of the waitlist. You know the categories where people need the resources, and you are choosing against responding to that waitlist. Why is that your priority?

Senator Colbeck: Senator, as the numbers in the budget and the numbers that I’ve given to you clearly indicate, we continue to grow the number of home care packages to continue to meet the needs of older Australians.

Senator O’NEILL: You are not meeting the needs of older Australians—120,000 of them are waiting.

Senator Colbeck: You can put the characterisation on it you like. We continue to invest in more home care packages, as I’ve indicated on a number of occasions, and as I answered in my response to Senator Hughes, to grow the number of home care packages and to continue to meet the needs of older Australians.

Senator O’NEILL: You are not meeting them, Senator Colbeck.

Senator WATT: What’s the current amount of unspent funds within the Home Care Packages Program?

Dr Hartland: It is about half a billion.

Senator WATT: Half a billion?
Ms Beauchamp: There is a Commonwealth component and a client component. The Commonwealth component—

Dr Hartland: It is $262.8 million. If you add the client component, ACFA estimate that it's around half a billion.

Senator WATT: If we're talking about Commonwealth funds, you're sitting on $262.8 million that's been allocated for home care packages while we've got 120,000 people waiting for home care packages and you're not spending it.

Ms Beauchamp: Senator, that characterisation about sitting on it—

Senator Colbeck: No, we're not sitting on any money at all.

Senator WATT: It's unspent funds. You are sitting on it.

CHAIR: Senator Watt, please let him answer the question.

Senator Colbeck: Senator, let the officials answer the question and you might actually learn something.

Ms Beauchamp: The characterisation about 'sitting on it' is not correct.

Senator WATT: Okay.

Ms Beauchamp: Without being disrespectful, I just want to say that the moneys have been allocated to people for home care packages. It's been allocated to the individual through the providers, so the money is sitting with the providers of the services provided to home care package clients.

Senator WATT: But there is $262 million of Commonwealth funding that has been allocated to be spent on home care packages that is not being used for those packages.

Ms Beauchamp: That's correct.

Senator Colbeck: It may be, Senator Watt, that some people have—

Dr Hartland: That they are not being spent by the client.

Senator Colbeck: Recipients of packages may have decided not to draw down fully on the package. So it's not a matter of us withholding or anything of that nature. Some of this is about the way that recipients of packages choose to utilise and activate their package.

Senator WATT: What impact does that have on the budget of the department or the budget of the government? Is that recorded as having been spent or is that recorded as unspent?

Dr Hartland: It is expended and sits with providers.

Senator WATT: Sorry, I'm having trouble hearing you.

Dr Hartland: Sorry, Senator. It's recorded as an expense by the Commonwealth. The funds sit with providers and are available to consumers to use when they see fit. The government is actually looking at improved payment arrangements that would address, in part, amongst other things, unspent funds.

Senator WATT: The last thing here—I know we're up against time—is there any work currently being done within the department in readiness for MYEFO around the provision of additional home care packages?

Ms Beauchamp: I'm not going to say what's in or out in terms of consideration of budget.
Senator WATT: Minister, are you able to enlighten us? Is there any possibility of some relief here in the mid-year outlook?

Senator Colbeck: The government will make announcements with respect to any funding allocation in accordance with its decision-making processes.

Ms Beauchamp: Chair, can I put on the record—

CHAIR: Certainly.

Ms Beauchamp: In terms of the growth in home care packages and funding, which the minister has outlined, I think from 2018-19 to 2019-20 there was a 36.4 per cent increase. The reason I'm raising it is that we're allocating about 3,600 packages a week. There's also a supply and capacity issue of the sector to take on the number of additional packages coming through the system. We've absolutely got to look at it in a very considered way. I just wanted to put on the record that a 36.4 per cent increase from one year to the next is quite significant. Thank you very much.

CHAIR: A final question.

Senator POLLEY: Isn't it the case, when you say you're delivering that many packages and there are restrictions, that it would also reflect on the government's inability to do anything about the work force shortages?

Senator Colbeck: It's also the capacity of some of the providers to provide the services, and that is an issue coming through. I think it is also important to note that we need to be careful in the way that we actually grow these services. There are risks that come with rapid growth, and we've seen those previously. I don't think I need to get into any discussion or debate around that. But we do need to continue to grow the sector. The demand for growth is not small, but it needs to be done in a way that we can ensure that recipients of packages get a quality and safe service. So we need to make sure the growth capacity is managed in a responsible manner. That's not in any way reflecting on any other part or any of the things that we've discussed before, but it is certainly an important consideration.

Senator O'Neill: Work force planning failure? That's what it is.

CHAIR: Minister—

Senator Colbeck: It's actually a growth issue. If you want to go down that track, we can make comparisons. I'd prefer not to, but it is certainly an issue and it's an issue I've obviously had some conversations with the sector about. Our regulatory oversight of the sector from that perspective is also an important thing that we need to consider as well.

Senator WATT: Chair, you were seeking advice from us about the program.

CHAIR: I was.

Senator WATT: We did have some questions for the aged-care quality portfolio—I've forgotten the exact name. We won't keep them here if other senators don't.

CHAIR: I think everyone else had exhausted the questions in regard to outcome 6, so if we're happy we will release the officers at this point that are attached to that.

Senator WATT: If others had questions in outcome 6 we would probably throw a few more in, but we won't do it if we're the only ones.

Senator Siewert: It's not fair to characterise it as 'exhausted the questions'.
CHAIR: Questions on notice; that's right. All remaining questions will be placed on notice. We will move to outcome 1 when we resume from lunch, which will be at 2 pm today. I will suspend until then. Thank you.

Proceedings suspended from 13:05 to 14:00

CHAIR: We will now move on to outcome 1.

Senator GRIFF: Professor Murphy, I normally ask you this question most times: I'm just following up on the status of the COAG Health Council work on the public disclosure of hospital admission performance and information as to what progress has been made in implementing that proposal.

Ms Edwards: I think, Senator Griff, we are following on from our discussions about the work that AIHW and others in the safety and quality commission are doing to provide the performance framework for hospitals and so on. If so, I might get my colleagues to come and provide the detail of that.

Senator GRIFF: Sure.

Mr McBride: The processes are continuing. There is a high-level strategic plan and a set of initial indicators. AIHW are working on a front-door approach so it will be easier to access and better understood. That process is continuing.

Senator GRIFF: Queensland have pretty much jump-started it because they made an announcement a number of weeks ago that they're going to start publishing hospital and clinician data ahead of all of this. Are all states at a similar level that you're aware of? You were looking to make the data consistent to be published.

Mr McBride: Everyone who is entering it is doing so with the intent of making the data comparable and showing the states are at various stages, but it's progressing quite well.

Senator GRIFF: What timing do you see for this being fully implemented?

Mr McBride: The framework was endorsed at the beginning of this year. I think the front door that will sort of channel everyone into it will be launched towards the end of this year, probably late December this year, and then it will build potentially over time.

Senator GRIFF: What do you mean by the 'front door'?

Mr McBride: I guess, rather than having lots of disparate data, a front-door concept is usually where you go to one place and that gives you the entryway into a common and comparable dataset.

Senator GRIFF: What indicators are you planning to start with? Will clinicians be one of the first indicators? Will it be broken down by clinicians?

Mr McBride: It's looking at the determinants of health, health status—so the health status incidence of heart attack, end-stage kidney disease, hospitalisation through injury and poisoning and babies born with low birthweight. And then it looks across effectiveness, safety, appropriateness, continuity of care, accessibility, and measures against that. It's mostly starting on the basis of what is measurable now and then over time it will build to a broader set.

Senator GRIFF: So at this stage there's no timetable for the presentation of individual clinician data?
Ms Edwards: A lot of this information is publicly available now on the AIHW website. If you search for the AIHW performance framework it will give you a shell of the matters Mr McBride has been talking about and some further information. That might help you, because I know you've got an ongoing interest in this issue.

Senator GRIFF: I have looked at that, but my particular interest is in relation to clinicians. I think when we first brought this up a couple of years ago there was something on another website so you could see the number of operations per procedure and revisions and the like on a clinician basis. That's an area I'm particularly keen on so the public can make an informed choice as to who they use.

Mr McBride: There is a parallel process going on which is looking at clinical registries. Those registries are at various stages of advancement, but some of those will start addressing the issues you mentioned.

Senator GRIFF: Just on those registries, is there a plan to integrate the joint registry with this data as well?

Mr McBride: Sorry, what was that, Senator?

Senator GRIFF: I can't recall the name of the actual registry now, but is there a plan to have the joint registry data incorporated into what is publicly available for people to see?

Mr McBride: Once again, various registries are at various stages, but it is hoped that over time we will get to that stage.

Prof. Murphy: The joint register is a public document, but it gives outcomes by types of joint. It doesn't give individual clinician-specific outcomes. It's mainly designed to report on the performance of the types of prosthetic joints used.

Senator GRIFF: But ultimately clinician data from orthopaedic surgeons and the like will be shown in the system?

Mr McBride: We're working with stakeholders. There are concerns about the behavioural response to that. So if we publish clinician-level data, will clinicians be more likely to self-select less risky operations, for example?

Senator GRIFF: It also means the public can actually see the number of operations that their preferred or initial surgeon has done so they can determine their level of competency. If you look at the results that have happened with a similar set-up overseas, the outliers tend to lift their game mostly and then some might exit. But it's important to actually have that on the public record so it effectively lifts the process for everyone.

Mr McBride: Those are the discussions we are having with registries.

Senator GRIFF: I have just a couple of other questions, not related to the same topic. There was a recent article from the US which reported that nearly 30 per cent of health care in the US is unnecessary. I certainly applaud the Australian programs such as Choosing Wisely Australia and MedicineWise. They are two very effective programs. I'm interested in whether the department has a view, like the US, that 30 per cent of medical care is deemed unnecessary.

Prof. Murphy: I'm happy to start. I think we all accept that there is significant waste in medicine. Choosing Wisely has been a really important initiative in looking at unnecessary investigations and end-of-life care which has no reasonable prospect of prolonging life.
Choosing Wisely is implemented in many hospitals across the country. From the department's point of view, we are doing a major bit of work. The MBS review has a focus on looking at those MBS items such as arthroscopy or MRIs at certain ages where there is no clinical utility. So the MBS review has been doing work in that place. We obviously actively participated in Choosing Wisely. End-of-life care strategies and palliative care strategies are really important to avoid waste. I think that a 20 to 30 per cent estimate is probably applicable in Australia. Much of that, of course, is in the state public hospital system, but there is also some in the private hospital system, which the Commonwealth funds through Medicare. I think the only way to really address that is by strong clinical leadership. I think all of the colleges have bought into Choosing Wisely now. I think you'll find that most public hospitals across the country now have a Choosing Wisely program.

There's a lot to be gained from automated systems such as electronic ordering systems. The Commonwealth will often use the PBS and MSAC processes to look at that lens as to whether there is a value proposition from a health intervention. It is a complex issue, particularly when we have an uncapped Medicare system, and people have to exercise that level of judgement. One of the biggest, I think, initiatives that Choosing Wisely is pushing is to empower the consumer to ask the questions: is this procedure necessary, is this test necessary and how will it improve my health outcomes? It's a challenge across every high income country, waste. Looking at the statistics of what we spend on health, we're not in the state of America, but we do have a problem with waste.

Senator GRIFF: So we could have a similar number. It could be around 30 per cent of our health budget?

Prof. Murphy: There are various estimates that that 20 to 30 per cent mark is probably accurate for most high income countries. It depends how you cut it.

Senator GRIFF: Have you looked at evaluating the effectiveness of Choosing Wisely so far?

Prof. Murphy: I don't think the department has done a systemic evaluation of it, but I think there've been lots of reports on individual initiatives, some at a hospital level and some at a broader level—

Senator GRIFF: That's only public hospitals?

Prof. Murphy: Generally at public hospital levels, but I think Choosing Wisely is now getting some significant leadership in the bigger private hospitals as well.

Senator GRIFF: Chair, I just have a few questions in relation to My Health Record, which is the next section, but if I can ask them now for the record because I think they will have to be taken on notice?

CHAIR: A question on notice. Okay.

Senator GRIFF: So if you're okay with me asking those questions in relation to the My Health Record?

CHAIR: Are you comfortable with that? Yes.

Senator GRIFF: The questions I have in relation to that are: what percentage of patients seen by a GP have their My Health Record accessed during consultation or immediately after? I'm not sure whether that is known, but I think that is an interesting question. I will run
through them, but I don't expect you'll be able to answer all of them. The next question is: what proportion of patients who attend an emergency department have their My Health Record accessed? What proportion of Australian citizens who have a My Health Record have accessed their own record, particularly if they are accessed more than once, apart from the initial setup? What degree, if any, of data mining has taken place so far in relation to the My Health Record? It is really those first three that I'd be interested in. I don't expect that you'll be able to answer them now, but if you can that's fantastic.

Mr Kelsey: If I could say, first of all, that we very much appreciate taking those on notice so that we can provide the most detailed data where that's available. We are aware of increasingly large numbers of patients and consumers accessing their health records. As things stand, since the expansion program was initiated at the end of February, 278,000 consumers have accessed their record for the first time and many others are accessing it on a more routine basis. I can certainly give you data on the number of hospital connections or the number of the activity within those hospitals in terms of document uploads, if that will help. But we will take, if we may, the specific questions on notice.

Senator GRIFF: So at this stage 278,000 out of 24 million, is it?

Mr Kelsey: Roughly speaking.

Senator GRIFF: Who have actually accessed their record?

Mr Kelsey: For the first time since opt-out. There are many others who are doing so, but since the point of opt-out.

Senator GRIFF: When do you think you will be able to provide those answers?

Ms McMahon: I can provide some statistics on hospital connections. We currently have 616 public hospitals and health services across the country connected to the My Health Record and 216 private hospitals and clinics also connected. In terms of volumes of documents, we currently have 4.7 million discharge summaries from hospitals in the My Health Record and a range of other things, so pathology reports, 22.41 million—a number of those come from the public health system but also the private system—and diagnostic imaging, 4.11 million reports as well. Those are the volumes.

Senator GRIFF: That's all useful, but again, as I read out the questions at the beginning, what is the proportion of patients who attended an emergency department and the like? If you could respond to those other questions on notice that would be appreciated.

Mr Kelsey: We will provide what we can.

Senator O'NEILL: Could I go to the Medical Research Future Fund? Thank you for the information that you tabled this morning. Obviously, that will need a bit of interrogation and probably some more questions on notice will arise. I understand that the MRFF grants have been made through a mix of competitive and targeted processes; is that correct?

Ms Edwards: That is correct.

Senator O'NEILL: Could you give me a breakdown of the two types—those that have been awarded through some sort of competitive process and those that have been awarded directly by either the minister or the department?

Ms Edwards: I will start with the headline figures and my colleague can provide further detail. Obviously, within contested and non-contested or limited contested there's a range of
different mechanisms. Generally speaking, of the 231 MRFF grants awarded as of 31 August, 170, or 74 per cent, of those grants were awarded through competitive grants processes.

**Senator O'NEILL:** You said that was 74 per cent?

**Ms Edwards:** Yes, if the maths in my brief is correct.

**Senator O'NEILL:** And then by deduction?

**Ms Edwards:** Twenty-six per cent were through other types of grant rounds, particularly through emerging priorities grounds and so on—things that needed immediate funding in order to do emerging priorities. As I say, those can be through a range of different mechanisms on which we could provide more detail, if required.

**Senator O'NEILL:** Thank you; if you can. With the 170 we've got through the competitive process, would you be able to give me the 61—the 26 per cent by other processes? Can you break that down?

**Mr McBride:** We can but we would probably have to take it on notice. We haven't organised what we've brought in that order, and we'd have to read through an enormous amount of grant processes. We can certainly do it but we probably don't have it for you today.

**Ms Edwards:** We have provided today on notice all of the grants that are executed. They don't indicate that, so we'd have to go through and indicate it on those. We could provide you with a revised version to indicate the manner of the grant.

**Senator O'NEILL:** I would appreciate that, if you could take on notice that detail. Could you give me a broad understanding of 'other'? What is it other than? Is it the minister or the department? What other range of distribution mechanisms are there?

**Mr McBride:** There are a range of processes. Even within 'other', there are organisations that have been through a selection process through NHMRC; then the minister gives the grant to that organisation once they've been preselected. But the whole process isn't open and contestable, and it goes from that to circumstances where, through consultation processes and others, we make recommendations to the minister. There are a variety of circumstances where those non-competitive grants can arise.

**Senator O'NEILL:** You have given me a range between, a selected group; you activate some money for them, which is how I heard your first description. With the second one, you have a consultation to discern that there is a need in a particular area and make a recommendation to the minister; is that correct?

**Ms Edwards:** The 170 we mentioned are the fully open, contestable, the full process—

**Senator O'NEILL:** I'm trying to understand the rest, the 61—26 per cent.

**Ms Edwards:** They might have been listed as priority but the NHMRC didn't have the funding for those, which were then picked off their list, all the way through to, 'My goodness, there's a huge emergency to fund research on this issue,' and selected in that way. When we provide the information on notice, you will see the range of those things. I don't think we've got the detail of how they fit in—

**Mr McBride:** All of those are guided by the priorities approach that the Medical Research Advisory Board has been through.
Senator O'NEILL: At the moment I don't understand the 'through to'. There might be 17 different mechanisms, by the sound of things; or are there only two ways in which you get the additional funds?

Mr McBride: There is the traditional competitive process, where we go through a contestable—

Senator O'NEILL: Put that aside; let's just talk about the 26 per cent.

Mr McBride: Beyond that, that MRFF is new and we are feeling our way through circumstances within those governing priorities that grants should be agreed upon, with the minister being the ultimate decision-maker.

Senator O'NEILL: You can see that I don't understand how that operates; could you provide me with a fulsome answer so that I can understand the ways in which this money is being discerned and distributed?

Mr McBride: Certainly.

Senator O'NEILL: I would also like the number of grants; and, in addition to the number of grants, the dollar value of each of the grants, if you could break that down—the 170 and the 61.

Mr McBride: Yes.

Senator O'NEILL: What's the rationale for not providing the funding through the competitive process?

Mr McBride: I think we've just been through that. The MRFF has been set up deliberately differently than the NHMRC, where there is, as I said, a priority process. Rather than have researchers come to the MRFF and say, 'I've got a great idea,' there is a deliberate process to set priorities which will help to channel research energy into areas that are under-researched.

Senator O'NEILL: Is there a research focus? Is there a guideline that you operate within or is it completely open to decision-making moment by moment?

Mr McBride: There is that priority-setting process that the Medical Research Advisory Board goes through. That guides the minister in his decision-making as to where research should be prioritised. Rather than have researchers come along with an idea that they want to pursue, we signal to the research community areas where there is a need for research investment, and that guides the decision-making process.

Senator O'NEILL: Is there a solid reason why the government couldn't set a research focus and funding quantum and then run a competitive process within those parameters?

Mr McBride: Once again, I think the MRFF has been set up deliberately differently than that, acknowledging that in certain emergency circumstances the government should be in a position to make funding decisions that channel research into those areas.

Senator O'NEILL: In what emergency circumstances has the government allocated funding?

Mr McBride: Not just emergency circumstances; that is one example. It's designed deliberately differently than most research grant processes. Some research grant processes would exclude certain research focuses that may be within the priority area, so it's been deliberately designed to accommodate non-competitive processes.
Senator O'NEILL: Are there any emergency circumstances that you are aware of where money has been allocated? What constitutes an emergency to get you access to this fund?

Ms Edwards: I think I said—if I didn't, I meant to say it—'emerging'. These are completely under-researched areas where there may be no key research happening at the moment, so there is a focus and a decision by government, working under the priorities and principles that have been set by the advisory committee, that those need an injection of research. As Mr McBride says, there might be areas of key research. We can think of an example. Endometriosis was one where the minister was really concerned that 10 per cent of women in Australia—five per cent of Australians, that means—suffer from this very difficult condition. It's something that's been really under-recognised, underdiagnosed, undertreated and under-researched. That would be an example of where the government would, working within the priorities and using a very reputable research sector, direct funding to that sort of research. That might be an example. When we provide the information on notice, you've got every grant there, but we haven't cut it in the way you are talking about now. We are happy to describe those; then you can assess why it is that there was a decision made that this area really needed to have some practical, quick, translational research to really address areas which, for no bad reason, simply haven't had the focus from researchers in the past.

Senator O'NEILL: When you send me the material on notice, you'll give me a funding allocation for the endometriosis initiative, for example?

Ms Edwards: You should have that already, but we will go through that list and make sure that we add the information you've asked for.

Mr McBride: The way it was selected.

Senator O'NEILL: Has the government awarded any MRFF grants on which the department has not provided advice?

Ms Edwards: No. We would definitely have provided advice before a grant was executed.

Senator O'NEILL: There would be no grants that were discerned just by the minister without you providing feedback or initiating?

Ms Edwards: There would have been no grant executed on which we didn't provide advice.

Senator HUGHES: Can I come back to the emerging areas? One of the areas that's coming through is endometriosis; can you explain the process for that grant and the patient focus within that?

Ms Edwards: I agree it's a very interesting area to discuss, but I don't know if we've got the detail on that particular one. You would see that, with the vast number of grants, we haven't got the detail on it. That's why I raised it because it's a particular interest of mine. Obviously, it's part of our women's health strategy. We probably haven't got the detail on it. But we'll be providing on notice all of the various things, and you'll see the enormous spread of research activities that are being conducted.

Senator HUGHES: It would be wonderful if you could include that.

Senator O'NEILL: Could I go back to the process by which the discernment of allocation occurs that isn't by competitive grant? Would the minister, for example, make an
announcement about something and then seek advice afterwards? Are there any that are announced without advice?

Ms Edwards: I have not experienced that.

Senator O'NEILL: The only announcements that have been made have been made on the advice of the department?

Ms Edwards: No announcement or grant would have been executed without us having provided advice. Obviously, the minister takes information from other places as well as the department, but there's no announcement and certainly no execution of any grant on which we haven't provided advice.

Senator O'NEILL: And you provided advice prior to an announcement in every instance?

Ms Edwards: We would have provided advice of some sort, yes.

Senator O'NEILL: Prior?

Ms Edwards: Prior.

Senator O'NEILL: Has the government awarded any MRFF grants which the department has recommended against?

Ms Edwards: We will take it on notice but the four of us are not aware of any. Obviously, where there is a process for any such instances—I can't recall any in my time but we will take it on notice to confirm that.

Senator O'NEILL: If you do identify any, could you provide the dollar value of such ones?

Ms Edwards: Absolutely. I'm reasonably confident that there is no such grant, but we will check.

Senator O'NEILL: I'll give you the opportunity to put this on the record: I'm sure you are aware of some concerns among stakeholders about the integrity of the MRFF.

Mr McBride: I would think that, in any field of research where there is a grant process, there are always people who are disappointed. It's a new and emerging field of research. I think it's fair to say there is some uncertainty in the sector as to how we work versus how NHMRC works. We are working with NHMRC to better communicate that to the sector. In that area of newness and uncertainty, and grants that can't possibly accommodate every research request, there will always be people who are disappointed.

Ms Edwards: Mr McBride is absolutely right, but can I say that the overwhelming reaction from the research sector every time I have engaged with them is enthusiasm and excitement about this huge investment of funding; and, of course, concerns about, 'Why did someone else get the grant and not me?' in a contested round and so on, or 'What's coming up next?' But the overwhelming reaction of which my colleagues and I are aware is enthusiasm for the program.

Senator O'NEILL: I can understand that there is always suspicion regarding 'why didn't I get the grant'; everybody would go through that. But the fact that 26 per cent of the funds are allocated through other processes, which is a new model, as you've indicated, Mr McBride, does lead to some concern when people are unsure about how that money is being allocated, to the degree that I am today. I don't know how the 26 per cent spend is discerned.
Ms Edwards: It's a changed process, as we've mentioned. We will provide you with advice on each one. As I say, there are instances of areas which have not been given due attention, on the policy view of either the department of the government, and the design of this is to make sure we do ensure that that sort of research happens. Something like health services research is something that has not had a lot of focus. I refer also to translational research, so that we get it into the wards quickly. That is the focus, using methods which have a lot of integrity and are robust but are different from the traditional ones, in order to ensure that research into non-traditional areas or ones like endometriosis and other areas of women's health, for example, actually get the attention they deserve. I trust that all of the information we will provide to you on notice will help to explain exactly how the process happens.

Senator O'NEILL: Great.

Ms Beauchamp: I think we've been relatively transparent around the information that has been tabled today in terms of every project that's been supported. If you look through the list, there is probably very little—probably none—that you wouldn't like to see funded. We have pretty strong governance arrangements around the MRFF as well, and program guidelines for each of the major programs that are undertaken under the MRFF. I think it is an innovative way of us ensuring there is proper governance, proper integrity in the process and that the money is being spent wisely. I wouldn't like to say there's been any compromise of integrity on the delivery of the MRFF.

Senator O'NEILL: I'm just having a look at them and I can see the detail here. Thank you very much. I will have to have a closer look at them afterwards. Can you give me the headline figures of the investment that supports the 170 successful competitive grant recipients, and the 61 others?

Ms Edwards: I can do that. Just a moment—I'm trying to go electronic and it's failing me. I may have to revert to old-fashioned next time. We may not be able to, sorry.

Mr McBride: Sorry, Senator, was your question about the characterisation of those?

Senator O'NEILL: Yes. There are 170 that received 74 per cent of the funding through the competitive process and 61 others, which accounts for the other 26 per cent. What's the funding allocation to each of those two categories?

Mr McBride: In aggregate terms?

Senator O'NEILL: Yes please.

Ms Edwards: We've cut the numbers in a different way as we've given you.

Senator O'NEILL: I see, yes.

Ms Edwards: So we may have to take that—

Senator O'NEILL: Maybe someone can work on that and come back to us.

Ms Edwards: We'll give it a go.

Senator O'NEILL: That would be much appreciated because I'm sure that somebody can get that on an Excel spreadsheet and do the calc very quickly in a way that is difficult to do with a hard copy.

Ms Edwards: We will come back to you.
Senator O'NEILL: I look forward to that. If I can go just to a couple of quick ones on My Health Record, you told the committee previously that 2.5 million Australians opted out of the My Health Record before records were created and another 30,402 Australians cancelled their records between 22 February and 14 April 2019. Can you tell me how many Australians have cancelled their records since 14 April?

Mr Kelsey: Yes. Let me just find the cancellation figures.

Ms Beauchamp: I did table some information this morning around both opt-out and cancelled records. We've had 23,528 records cancelled since 22 February 2019. At the same time 22,129 people have opted back in since the same time as well.

Senator O'NEILL: I think we might have a couple of questions on notice but also I notice you've provided us with some data this morning that might be helpful in discerning that. If I can now go to the NHMRC IT project?

Senator ROBERTS: On the My Health Record data, the government has delayed implementation and invested vast amounts of money promoting the My Health Record to achieve its current implementation level. Has the time and extra cost been worth it?

Mr Kelsey: Currently almost all public hospital services are connected to My Health Record and where discharge summaries are being created those are being uploaded where a person doesn't withdraw their consent. We have now got to a point where well over 80 per cent of community pharmacies for the first time in Australia are uploading dispense medicine information from the My Health Record. We have got the vast majority of public pathology and radiology services uploading to the My Health Record and a very significant proportion of private radiology and pathology services uploading. This is really the first time, certainly the first time in Australia, that these kinds of data have been available to front-line clinical staff and of course the consumer so that at the point of care in real time this information can be shared. We put in place a whole series of different methodologies to evaluate the impact of My Health Record. Obviously it's early days but we are seeing very clearly from the clinical front-line very meaningful impact being achieved, particularly through access to medicines information. For example, in Royal Perth Hospital the toxicology department and the emergency department now mandate the use of My Health Record when it is triaging patients with suspected overdoses or other poison incidents so that their previous history of medication, and particularly those that have been dispensed, can be ascertained by emergency staff. That is just an example of a trend in hospitals in particular. Obviously out of hospital clinical staff are beginning to really value access to this kind of critical information at the point of care.

Senator ROBERTS: Presumably it would improve care and also health?

Mr Kelsey: Yes. What we're hearing is a range of improvements that are being facilitated, which range from, frankly, outcomes being improved in the emergency department because for the first time emergency physicians can see what medicines have been dispensed to a person, right through to just better coordination of care in the out of hospital environment. So people are able to be discharged into a knowing relationship with out of hospital clinicians. Care plans can be more easily developed—a range of benefits which are beginning to be realised in the Australian community. And what we look forward to doing, of course, is...
bringing back over the coming months more statistical evidence of that impact being realised on the ground.

Senator ROBERTS: There was a breach of security in Victorian hospitals recently apparently—access to people's records. My Health Record stores a large amount of very confidential information about Australians and it would be like having one's whole life exposed if they were compromised. What are the safety precautions you've taken to make sure the information is kept confidential and, in particular, is the record stored in Australia or overseas?

Mr Kelsey: So that I can be crystal clear about this, no health information, no information on the My Health Record, is stored overseas. It is prohibited, firstly. Secondly, the Victorian hospital issues didn't in any way affect My Health Record or the integrity of the My Health Record system and, thirdly, as I've had the privilege of describing this to estimates before, we have in place a series of very advanced cyber security protections for the My Health Record. I'm very happy to list some of those for the committee, but as you would imagine, we operate to the highest standards, assured and audited by other government agencies, including the Australian Signals Directorate, to that effect. There have been no instances of security breach of the My Health Record but at the same time of course there is no absolutely no complacency, and we are constantly reviewing ways to improve the cyber security protections of the My Health Record through our dedicated cybersecurity centre.

Senator ROBERTS: What about general practitioners' records on the cloud?

Mr Kelsey: We don't operate cloud services for general practice.

Senator ROBERTS: Can people access general practitioners and then get in through there?

Mr Kelsey: No, they can't.

Senator ROBERTS: We've also heard—I don't know if it is true—that specialists aren't receiving anywhere near the same level of support to adopt the My Health Record as that provided to GPs. That was a mistake the British apparently made and it slowed down the adoption of their records system. What have you done to make sure that specialists get adequate training as well as GPs?

Mr Kelsey: Perhaps I could ask my colleague to answer that question.

Ms McMahon: Over the last three years of the agency's operation we've focused initially on general practice, public and private hospitals, pathology sector and pharmacy. This financial year we've started focusing on specialists. When we appeared before this committee in February we reported at that point that in addition to the public health system, because of course specialists do work in public hospitals and private hospitals and access the record that way, we had 271 medical specialist organisations in February who were directly connected. That's increased 185 per cent since our last appearance; so we now have 742 medical specialist organisations. We are also working directly with a number of software providers who service medical specialists to improve the usability of software and the way it connects and uses the My Health Record to improve the experience of those specialists in connecting to this information.

Senator ROBERTS: How far do you have to go? How many agencies or how far down the track are you as a percentage of capturing your target?
Ms McMahon: In terms of the software vendors?

Senator ROBERTS: No, in terms of how many other specialists, how many other health practitioners?

Ms McMahon: I will need to provide the denominator to you on notice. We've got a number of specialists working in the public and private hospitals. In terms of them practising through their rooms, I will need to take that on notice too to find the total number.

CHAIR: I think we have come to the end of outcome 1 and we are ready to move into outcome 2; so we will release any officers involved in those. Thank you. Senator O'Neill, did you want to start?

Senator O'NEILL: I understand outcome 2 is relevant for the NHMRC IT project. I understand the NHMRC is in the process of developing a new grants management service called Sapphire. Is that correct?

Prof. Kelso: That is correct.

Senator O'NEILL: I have in front of me the original contract notice for this project published in 2017 and, just looking at that original contract notice on AusTender, it appears the original contract value was $2,268,858. Is that correct?

Prof. Kelso: I don't have the figures in front of me but I can confirm that on notice.

Senator O'NEILL: I've got a CN ID number. Does that help?

Ms McLaughlin: We don't have those details with us at the moment. We would be able to bring those back to you later in the day if you let us know exactly what it is you wanted confirmed.

Senator O'NEILL: I do have some quite detailed questions about that; so if you want to do it a bit later and you need to get more information here, I do want some answers today if I can.

Ms McLaughlin: Okay.

Senator O'NEILL: There appear to be a number of amendments to that funding. My questions would go to that. Are you able to answer those now?

Ms McLaughlin: It would be better to come back with more information on that later in the day.

Prof. Kelso: Although it may be helpful to know the specific questions in case we come back and still don't have the information we need to answer directly.

Senator O'NEILL: I'm looking at it and I'm trying to figure out exactly how much money is really there now. I just want the accurate details. Is that clear enough?

Ms McLaughlin: Yes, absolutely.

Senator O'NEILL: If you could get that, that would be really good.

Ms McLaughlin: We will come back with that, yes.

Senator O'NEILL: I would appreciate you being able to provide any advice you received around the way in which you managed that, if you received any legal advice. I think that
would probably give you a sense of the direction in which I want to head. How long do you need to get across that detail, Ms McLaughlin?

Ms McLaughlin: Probably half an hour.

Senator O'Neill: Fantastic, thank you.

Senator McCarthy: Can you provide an update on the government's 'towards zero' suicide strategy?

Ms Edwards: There are a couple of pieces to discuss here. You would recall that we've previously discussed ongoing work in relation to suicide prevention that is managed from within the health department. I can provide an update on some of those activities. One of the major things that has happened in the last few months is the Prime Minister has moved to appoint Ms Christine Morgan as the National Suicide Prevention Adviser, reporting directly to the Prime Minister and supported by a task force which is hosted in our department. That task force is led by Ms Morgan's special adviser, Ms Jaelea Skehan, who has deep and extensive expertise in suicide prevention research, policy and practice. She reports to Ms Morgan and has oversight over the content of what the task force does day to day. The task force is staffed by Department of Health officers but also seconded officers from a number of departments, the aim being to have a whole-of-government multidisciplinary task force that will assist Ms Morgan to report back to government. It's also assisted by an interdepartmental committee, which I chair jointly with a deputy secretary from the Department of the Prime Minister and Cabinet and which involves a large number of agencies brought together to look across the whole spectrum of Commonwealth activity. Suicide has been elevated to a very high priority for the COAG Health Council and also has been raised in relation to the COAG of First Ministers. So activity is happening at a range of levels. At the same time we are continuing to implement, monitor and evaluate all of the ongoing activities that were announced in the recent budget and in the period since.

Senator McCarthy: So is this activity explicitly part of the government's Towards Zero Suicides strategy?

Ms Edwards: Those activities are aimed at preventing suicide in Australia, with the aim being to move towards zero suicides as the only acceptable outcome.

Senator McCarthy: Is there a time frame for this strategy?

Ms Edwards: There are some time frames involved in the activities that are happening in terms of Ms Morgan's appointment and so on. We haven't put a time limit on when we would aspire to have zero suicides. That's for obvious reasons. The government's decision is that there's no appropriate target and time line because we want to reduce suicides to none so that no families, communities or individuals have to suffer the great distress that a completed suicide brings, and also work with people who self-harm or attempt suicide. If the question is when do we think we'll have zero suicides, there's no answer to that question, but it's very much front and centre for us—that's where we should always be aiming through our efforts.

Senator McCarthy: But no doubt there are conversations about a particular time line. We talk about not wanting to have poverty. It is a key awareness.

Ms Edwards: One of the things we are doing in the course of this work is trying to get hold of the data. Both in the department and in the Suicide Prevention Adviser's task force, we are drilling down into the data as to who is affected, how it's made up, and what specific
strategies might be needed, for example, to deal with Aboriginal and Torres Strait Islander people, who make up an unacceptably high proportion of completed suicides in Australia, but also other groups. When you look at the data you see that there are large numbers of suicides in remote and regional areas as opposed to in the cities, again disproportionately high impacts. We are thinking hard about the impact which drought and other issues in the community are having on people's mental health and also the mental health of older people. It's a broad-ranging strategy. We will take our lead from the advice that the Suicide Prevention Adviser gives. She's the expert who's been appointed and has this task force. In the meantime, the department is continuing to implement and assist the task force, the adviser and the government on what is happening. Importantly, we are responsible for the intergovernmental arrangements through the COAG Health Council and its supporting committees to make sure that we work with all states and territories. There is also the Fifth National Mental Health and Suicide Prevention Plan, which we work on jointly with states and territories. It's a complex issue and ranges across a lot of areas, so our response is being targeted accordingly. We are open to views and input as to how we might improve it and other initiatives.

Mental health is a focus for the government and for the department, starting with children and working all through the life course, and suicide prevention is an overlapping area. Suicide, we appreciate in the Department of Health, is not always mental health related, and so the work of suicide prevention and of the Suicide Prevention Adviser is broader than mental health, but it's a major contributor. We have to marry up those issues closely.

**Senator McCarthy:** What other advice did the department provide to the Prime Minister and the minister on the 'towards zero' suicides strategy other than the interdepartmental and task force advice?

**Ms Edwards:** We don't advise the Prime Minister directly. You would have to raise issues as to advice to the Prime Minister with the department of the prime minister. Suicide prevention and mental health are matters on which we advise the Minister for Health, and also Minister Colbeck and Minister Coulton, frequently in terms of the programs, what is going on, what's happening in the community, groups that one or other of the ministers is meeting with. Our briefing to the ministers on mental health would be numerous written documents per day, numerous meetings in a week with the office or with the minister, and frequent meetings and engagement with stakeholders. So it's probably the most intense briefing arrangements, certainly in my area of the department.

**Ms Beauchamp:** We engage with the PM's adviser on a regular basis. I think Ms Edwards has already spoken about how we are supporting her in that role. This is a multifaceted approach, so Ms Morgan has been around the country having conversations with particular communities for different aspects—drought, Aboriginal and Torres Strait Islanders; that has been far-ranging. But we are also conscious of the need to ensure there is more access to community-based programs, and online support. We are focusing on youth suicide prevention as well. So a number of initiatives are being rolled out at the same time that advice is going forward to the ministers and the Prime Minister.

**Senator McCarthy:** Ms Beauchamp, which Indigenous communities has Ms Morgan met with?

**Ms Beauchamp:** Christine Morgan, the adviser, is going around meeting with a number of communities separately.
Senator McCARTHY: Do you want to name them?

Ms Edwards: We can provide you with that on notice. She is independent to us; she reports to the Prime Minister, so I don't have the detail of her meeting schedule—

Senator Colbeck: The process is a very open one. I have a copy of the letter from Minister Hunt to Mr Bowen and Mr McBride giving them the opportunity to engage with Ms Morgan and, for example, the Parliamentary Friends of Suicide Prevention. So the consultation is broad and open and not restricted in any way. I don't think any of us pretend to have the answers individually and we are open to thoughts from all quarters.

Senator McCARTHY: Ms Beauchamp raised it. Given that the highest suicide rate is with First Nation communities, I thought you'd have that answer with you.

Ms Edwards: Because Ms Morgan is also the CEO of the National Mental Health Commission she is here today, having been called by the commission. So perhaps when the commission is up you might want to ask her about her activities.

Senator McCARTHY: Sure.

Ms Edwards: She is probably listening; she's been heavily involved in that activity, and I'm sure she'd be happy to take you through it.

Senator McCARTHY: Absolutely.

Senator O'NEILL: I want to get some clarification. You said in your earlier remarks, Ms Edwards, that zero is a target that is perhaps unreachable for obvious reasons, as much as it might be desirable.

Senator Colbeck: I don't think she said it was unattainable. She said it was the only acceptable target.

Ms Edwards: An aspiration and the only acceptable target, I think I said, but not something we can put a time limit on—for obvious reasons.

Senator O'NEILL: We can check the record. Was it the department that determined that the zero target was the strategic goal? Did you provide advice to the government telling them that they should have a towards zero strategy? Did that come from the department?

Ms Edwards: We provided advice on data strategies information, but it's not for us to determine the strategy for the government. There are plenty of other people with way more expertise than I or people in my team on suicide, including the suicide adviser and other groups.

Senator O'NEILL: You didn't offer up to the government, 'We think you should advance a towards zero strategy'? That is their nomination?

Ms Edwards: I wouldn't normally discuss with the committee the detail of the advice. But I can say that this is a government decision in terms of what aspiration the government has for combatting this difficult and complex issue. The conclusion that the government has made is that no target other than zero would be acceptable, and that is the one we are working towards.

Senator O'NEILL: I think I understand what you said. I want to ask one further question to clarify. Is there an explicit 'towards zero' suicides strategy document? Does such a thing exist?
Ms Edwards: Ms Morgan has been charged with developing advice to government on what we should do.

Senator HUGHES: With regard to the suicide target, is there any international evidence or evidence that we can look to for providing a target other than zero? I agree with you that zero is absolutely the only acceptable number we should be aiming for.

Ms Edwards: There is a lot of evidence and international information, but I would again defer to Ms Morgan to provide the detail. We have an expert with a task force to provide this sort of advice, and I defer to her. You might want to ask her about it.

Mr Roddam: We should also mention in the context of this discussion that Ms Morgan's terms of reference are publicly available and that they guide her work to a great extent as well.

Senator O'NEILL: But, to be clear, no document exists that is a 'towards zero' suicides strategic document plan? If I went looking for it, I wouldn't find that anywhere?

Mr Roddam: There are three dates on which Ms Morgan is due to report to the Prime Minister: in November this year with initial advice; then an interim report in July next year, and a final report with recommendations in December next year—that advice will contain a lot of that information.

Senator O'NEILL: Which is a little concerning, considering the government announced an explicit 'towards zero' strategy in July of this year and the document doesn't exist. The whole plan for that doesn't exist.

Ms Edwards: Which announcement are you referring to, exactly?

Senator O'NEILL: There was a 'towards zero' suicides strategy announcement by the government in July.

Ms Edwards: Have you got a date and a reference?

Senator O'NEILL: No, I don't at hand.

Ms Edwards: That's all right. Perhaps we could have a look in the break and see what the document says, but the strategy of the government is that it wants to work towards zero suicides. We have activity in train already which we are working hard at implementing and monitoring. In addition, we've asked for expert advice from Ms Morgan and her team and the work she's doing on what the appropriate next steps should be to move towards zero suicides.

Senator HUGHES: Senator O'Neill, Ms Morgan's work is towards the strategic outcome as opposed to no programs currently happening; is that correct? She is putting together the strategic document?

Ms Edwards: She is definitely putting together advice.

Senator HUGHES: There are still programs occurring, yes.

Senator McCARTHY: Can I just ask how many suicide prevention trial sites are currently operational?

Mr Roddam: Twelve.

Senator McCARTHY: In what way are they operational?

Mr Roddam: There are 12 distinct suicide prevention sites. They all have different models that they are trialling and different ways in which they're operating. We did, in the last
estimates, table an update on the 12 sites and the activity going on within them, which we have updated and which we're happy to table, if that would assist.

**Senator McCARTHY:** That would be really good. How much funding has each suicide prevention trial site actually received?

**Mr Roddam:** It's around $1 million for each site per year.

**Senator O'NEILL:** For remote communities is any additional funding allocated for the extremely high costs of people moving around in those districts or are they required to provide the service in remote north-west Western Australia without additional funding?

**Ms Edwards:** It's not a service provision; it's about funding, through the PHN, a community strategy, so it's not service delivery in the same way. Of course, where we deliver services in remote areas, it's a more expensive endeavour, and they're funded differently. But, in relation to this, it's $1 million per site per year in order to bring together stakeholders and come up with strategies for moving forward, and it's the same amount for each site.

**Senator McCARTHY:** That $1 million has been delivered completely to all 12 sites or is it rolled out?

**Senator O'NEILL:** One million dollars per annum.

**Mr Roddam:** Each year it's been approximately $1 million that the trial has been operating at per site.

**Senator McCARTHY:** Can you provide an update on outcomes for each of the prevention trial sites? Is that what you're tabling?

**Mr Roddam:** Yes, that would be the best way to do that.

**Senator McCARTHY:** Okay. We'll have a look at those. That's happening now, isn't it?

**Mr Roddam:** I can do that.

**Senator McCARTHY:** Please, so we can have a look at that. Otherwise I may be asking you questions that are already on there. Recent research has shown that the rate of suicide is 2½ to three times higher in Australians who live within the lowest two quintiles of household wealth than those in the top quintile. What action is the department taking to address this inequality?

**Ms Edwards:** Obviously, there's a range of activity happening in the suicide prevention area. I can't point to a particular stream of funding which goes particularly to the issue you're alluding to, although it is one that we're aware of. There is obviously a higher prevalence of suicide and self-harm and so on in some communities than others. We have a National Suicide Prevention Leadership and Support Program, which invests in a range of national projects designed to reduce suicide and suicidal behaviour across the population. That's just one example of the way the program works, but there are a whole range of things that happen under that head. We can provide all the detail that you like about the various streams, but I can't point to the 'this is the low socioeconomic particular stream'—

**Senator McCARTHY:** Situation.

**Ms Edwards:** It's not the only risk factor. In fact, the largest risk factor for suicide, sadly, is a previous suicide attempt. That's one of the reasons we're investing heavily in discharge assistance for people, working with states and territories, in terms of how we make sure
people get support after an initial attempt, for example. But low socioeconomic is a risk factor and it's one we're looking at. It would be a factor which, no doubt, Ms Morgan and her task force would be looking at in terms of how we target the activity we do next or additional to make sure we get to the risk factors that are at play.

Senator McCARTHY: In my community of Borroloola in the Gulf of Carpentaria, for example, we have suicides too often and one of the concerns that comes back from family members is that they've not had the opportunity to even debrief or talk about the suicide before the next one happens. The most recent one concerns two brothers. One died a year ago and then his brother decided to do the same thing 12 months later on his anniversary. The families just feel completely helpless. They've got no-one to talk to and no understanding of how they can help their family members deal with these issues. What can the department do in terms of identifying particular places that are at far greater risk where it's happening far too often?

Mr Roddam: I'm not sure if the family you're referring to was Indigenous, but we do have—

Senator McCARTHY: Yes, they are First Nations People.

Mr Roddam: We have a number of First Nations specific suicide prevention programs and mental health initiatives. Of the $503.1 million youth and Indigenous mental health and suicide prevention plan, $34.1 million was for Indigenous-specific suicide prevention initiatives, with $1.2 million for Red Dust to deliver social and emotional well-being activities in the Northern Territory; $5 million for young Indigenous leaders to participate in place-based cultural programs and around about $19.6 million—which may be more appropriate to talk about on Friday when the National Indigenous Australians Agency are here. There are a number of investments from them, including expanding Aboriginal mental health, first aid and other activities in the Kimberley. The government's also recently announced it is providing $4.5 million for the Gayaa Dhuwi (Proud Spirit) Australia Indigenous leadership body to create a national plan to improve culturally appropriate care, focusing on empowering young leaders within communities, which is particularly important in relation to the issue you're speaking about.

Senator McCARTHY: What about in schools, Mr Roddam, given that a lot of our kids—again First Nations kids in these instances—as young as four, six and eight are either attempting or actually succeeding in suicide? What kind of work is the department doing with education?

Mr Roddam: There are some programs specific to schools. One is the Be You program being rolled out through Beyond Blue. They're doing a lot of that work. We also have a headspace in Schools program—

Senator McCARTHY: Where is Be You being rolled out, which schools?

Mr Roddam: Be You program operates in a number of schools, particularly in relation to communities with a significant proportion of First Australians. There is a targeted pilot Be You program being rolled out in the Kimberley and the Pilbara, starting in the first term of 2020.

Senator McCARTHY: So it hasn't started yet?
Mr Roddam: That one hasn't, but the Be You program more broadly Australia-wide has been operating since 2016-17 and is funded through to 2020-21.

Senator McCarthy: Is that schools in the southern states?

Ms Edwards: There's a large number of schools involved in the program across all states and territories. The pilots that Mr Roddam is talking about were two that came on late and have been accelerated in the Kimberley and the Pilbara because of the concerning incidents we've been having up there with the coroner's report and other activities, so that one has been brought forward and put into place more quickly, but it is occurring across all states and territories.

Mr Roddam: To give you some statistics, as of 30 September this year there have been 2,817 early learning services—so they may be schools or early childhood centres—participating in Be You; 85,312 individual users have registered. The percentage of Australian schools by state and territory participating in Be You is 53 per cent in New South Wales, 72 per cent in Victoria, 63 per cent in Queensland, 66 per cent in Western Australia, 81 per cent in South Australia, 90 per cent in Tasmania, 91 per cent in the ACT and 94 per cent in the Northern Territory.

Ms Edwards: It's also important to note that all schools and early learning centres can enrol to be involved with Be You—we're wanting schools to come to it—and so can individual educators. What we're aiming to do here is to give schools and educators the tools to help kids in the manner you've discussed. To go back to your previous question and a very distressing, terrible story in Borroloola in your area, we don't have a trial in the Borroloola area at the moment, but we do have services that outreach to that and we are aware that we need to do more.

Senator McCarthy: What are those services?

Ms Edwards: There are mental health services across the territory. The point I'm trying to make is that we realise that this is a very difficult situation and unacceptable, which is why we're going towards zero. We also realise there's more to do. We also realise we have to move very carefully so that we don't inadvertently do something that can actually have an adverse effect. It's one about which I think it's fair to say there is bipartisan and enthusiasm by everyone in order to do better for all Australians who might attempt or complete suicide, but particularly for Aboriginal and Torres Strait Islander people, because we've seen such distressing incidents that we want to stop. We realise that we're not doing enough. We realise that we don't have all the answers. That's one of the reasons we're really pleased that the Prime Minister has appointed an expert to lead us and to provide advice on what to do next. When we hear stories like the one you provided, which we very much appreciate you sharing, it inspires us further to ask: what do we need to do next? I can assure you that it's a very genuine commitment by the government—no doubt by all members of the parliament and certainly by bureaucrats. The interdepartmental committee, for example, that I co-chair on this, has been one of the most engaged, positive experiences of the public service because it's the whole of the Commonwealth coming together to address this issue. We appreciate you sharing the experience, and we'd be happy to take away any information you've got about what's going on to see how we can respond. Together we need to move forward to do better and work towards zero.
Senator McCARTHY: Will those intergovernmental agencies head out to these communities or meet on those lands?

Ms Edwards: Not as a group. Ms Morgan, as she can tell you herself, has been doing all sorts of travel, as much as is possible for one person to do; she's really been out a lot. We involve ourselves with remote communities to the extent we can. Obviously, the National Indigenous Australians Agency has people out on the ground all over the place, and we certainly encourage all agencies. Something like Services Australia obviously have people all over Australia also, and that's why they're on the IDC—to talk about how they engage with people. We're also talking to departments, industry, the tax office and everyone, saying: 'Where does the Commonwealth touch people? How can we make sure that that engagement is better?' So together we can work towards doing more about preventing suicide in Australia.

Senator McCARTHY: Does the department coordinate which funding is granted to mental health organisations or is this a ministerial decision?

Ms Edwards: By and large it's ministerial decisions or, in some instances, whole-of-government decisions based on departmental advice.

Senator McCARTHY: What due process does the department go through in allocating funding to mental health organisations?

Ms Edwards: It depends on the program. There's $5.2 billion a year of Commonwealth funds spent on mental health overall, of which about $800 million a year is Department of Health specific programs. Obviously there's a whole range of different ways in which that money is applied.

Senator McCARTHY: Are you able to describe the application process or the due diligence the department completes when allocating funds?

Ms Edwards: Again, it depends on the program. I would point out that a large proportion of the Department of Health funding—the $800 million a year—something like $400 million a year, is passed through the Primary Health Networks, who are charged to research and find out the needs in their community and commission services. That's in order to have that commissioning happening close to the ground on the basis of needs in particular places. Other parts of that funding is delivered in different ways. So there's a range of arrangements, but we're always subject to and comply with the financial rules of the government, and we make sure that it's fully accountable and appropriately allocated.

Senator McCARTHY: The government's announced that a new suite of 64 Medicare Benefits Schedule items will be introduced to support a model of best practice evidence-based care for patients with anorexia nervosa and other eligible patients with eating disorders. Can you please confirm what consultations occurred before this announcement was made?

Ms Edwards: We might need to work with our colleagues from the Health Financing Group because that went through the MBS processes. If they're not here at the moment, can we ask for that to be re-asked when health financing are here in relation to those items? They'll be able to provide you with the detail of it.

Senator McCARTHY: Okay.

Senator O'NEILL: Thank you for the information that you provided here about the trial sites. I don't think we can be unclear about the outcome of that. The idea is to reduce suicides
in the communities that were identified. Senator McCarthy asked the question: what are the outcomes that have been achieved in these trial sites? I've looked at the list of trial activities, and I'll probably ask a couple of questions about this. Do we have a reduction in suicides in these areas where the trials are operating?

**Mr Roddam:** No, we don't have the data. We know that over the last year nationwide there were about 82 less suicides than the year before, as reported by the Bureau of Statistics, but we haven't given—the regional figures as per the suicide prevention trial sites aren't available.

**Senator O'NEILL:** Why not, Mr Roddam? I would think that would be the very first measure that you would be able to report on. If this is about reducing suicides in identified areas of high risk and high representation of death by suicide, I would be very interested to see if what's going on already is having any impact on the rate of suicide completions in those contexts.

**Mr Roddam:** In terms of the trial sites themselves, the University of Melbourne is undertaking an evaluation at the moment of the 12 sites. As I said before, a different approach is being undertaken in each site, so that will give us some rich evidence in terms of which activities within those sites have succeeded.

**Senator O'NEILL:** That is a methodological analysis; is that correct—to see whether the programs, the trial activities, are having any purchase?

**Mr Roddam:** Yes.

**Senator O'NEILL:** But the measure, surely, would be a reduction in death by suicide. Is that being measured in those contexts?

**Ms Edwards:** It would be, but some of the trial sites are doing activities, as you will be able to see, which are to do with people at that very difficult end where they may have had an attempt, but others are about improving community connectedness in schoolchildren, with a view to giving those children, when they grow up, perhaps many years hence, more resilience and ability. The measure of how well we are doing with these trial sites is more complex.

**Senator O'NEILL:** How many measures are you measuring?

**Ms Edwards:** The evaluation is looking across a range; that is independently run. We are asking them to tell us how they're going.

**Senator O'NEILL:** You've asked them to tell you how they're going. Have you directed them as to what you wish to measure?

**Ms Da Rocha:** The Melbourne university is doing the evaluation of the trial sites. That evaluation will be finalised by December 2020, so at this stage we don't have that level of detail.

**Ms Edwards:** We're not running the evaluation. We're letting the independent evaluator design the evaluations, as opposed to telling them what to measure. That's one of the key indicators of a robust, independent evaluation.

**Senator O'NEILL:** I understand the value of independence and of experts in terms of evaluation of a research project; undoubtedly. As the agency that is responsible for the expenditure of the government's investment in this, I would have thought that, if you actually
do have a towards zero strategy, you would absolutely be measuring very accurately the actual suicide rate because that is a critical factor that you are seeking to address.

Ms Edwards: As I mentioned, that's absolutely one of the things, but we couldn't limit it for the reasons I've mentioned.

Senator O'NEILL: I'm not seeking limitation. I'm asking if you are measuring that and if you can give me an indication that the money that has been expended so far has had any impact.

Ms Edwards: We're improving our data collection. Obviously, the data on suicide attempts, completed suicides and the behaviour that goes with it, is not as good as we would like it to be. That's why we are investing in that sort of data. That's where we're going. Of course, measuring is an important part of what we're doing. It's not the only part. Having communities come together and have strategies of their own is a lot of it. Some of these trial sites are more advanced than others. That's because it's been harder for people to come together, trust one another and discuss what, as Senator McCarthy is pointing out, are very difficult, personal issues. Success in one place may be slower and of a different nature than another.

Senator O'NEILL: If I go through the document I can look at country WA, for example. This shows progress at October 2019. When has it been going from? When did it start?

Ms Edwards: I've got funding since 2016, but I'm not sure if—

Senator O'NEILL: We are into the third year.

Mr Roddam: 2016-17—

Senator O'NEILL: That's my understanding. We are into the third year, because we fought very hard for an extension of funding for an additional year. These sites were so slow in getting off the ground that we fought to make sure there was a funding allocation to allow actual implementation to occur. It concerns me somewhat that in country WA the first item of the evaluation that you've given me here says: 'PHNs engaged with local communities and a midwest suicide prevention steering committee has been formed to lead the trial.' Three years in and that's the report of progress' that the steering committee has been formed.

Ms Edwards: I think you're looking at the midwest region, not country WA?

Senator O'NEILL: It says 'country WA' and that is the midwest region.

Ms Edwards: The midwest region of country WA; I understand.

Senator O'NEILL: You can understand, when I read that three years in, it's a little alarming.

Ms Edwards: I don't think that means it happened in October.

Mr Roddam: No. This is a cumulative—

Ms Edwards: We've updated this as we've gone along.

Mr Roddam: In fact, in the next paragraph it talks about activity in Christmas 2017.

CHAIR: And an event on 4 April

Senator O'NEILL: I don't know that that necessarily flows on from the first one. I was unaware of—
Ms Edwards: What we've tried to do is to give you as much information—

Senator O'NEILL: This is everything that's happened between 2016 and 2019?

Ms Edwards: It may not be everything that's happened, but it's an attempt to put together a story of what's been going on in these trials for the benefit of the committee.

Senator O'NEILL: An earlier question I had—please help me to try and understand this—was that there is an investment here and you, if I heard you correctly today, told me that investment in the suicide prevention trial is to create a strategic plan, not to provide services. Yet as I read this document—looking still at country WA, the Kimberley region—it says that KAMS have employed two young Aboriginal and Torres Strait Islander people to be trained to deliver youth mental health first-aid training.

Ms Edwards: They choose what they want to do with this money.

Senator O'NEILL: Services are being provided as part of this. It's not just a plan, is it?

Ms Edwards: It's about each area coming up with what they think they need to do in order to bring together and further suicide prevention. We're not saying that's the money for services to prevent suicide in that region. On the contrary, all of the other programs that we manage, or that the state might manage, continue.

Senator O'NEILL: If they sit outside it, what I want to really understand—

Ms Edwards: Sit outside what?

Senator O'NEILL: If the service provision that you were talking about sits outside this, as a general service provision into that area, I'm trying to understand exactly what is going on in these prevention trial sites.

Ms Edwards: I don't think it sits outside it. For example, in Darwin the group there includes government representatives who would be representing how services might be integrated into what they're doing, to provide information.

Ms Da Rocha: There is a significant focus in the Kimberley around youth. There are nine different sites in the Kimberley focused on in this trial. There's a significant focus on making sure that youth have a clear leadership role. Community liaison officers are employed in each of those nine sites to do work. Again, this is absolutely community-led, and each of the communities works with a PHN to work out what they want to do in each site.

Senator HUGHES: With the sites, is there any real-time monitoring of suicide clusters or where the government needs to focus attention with regard to where these trial sites are or where groups are sent, so that we make sure they are in the right areas?

Ms Edwards: Not sufficiently; that has been the historical situation. That's why in the budget there was a commitment—was it $15 million?

Senator HUGHES: So the last budget had a commitment of $15 million?

Ms Edwards: In the last budget, for AIHW to really work on how we can get—I don't know if we'd ever aspire to real real-time, but very quickly, and to try and bring together data. At the moment we know that sometimes coroners report deaths in a different way. It's about trying to get some consistency across that, trying to do work regarding what ambulances are telling us. It's about trying to make sure that the data we've got about what's going on is much more quickly brought together and can be acted upon.
Senator O'NEILL: Is that happening at a statewide level or is that aggregation of data in real-time only happening in the trial sites?

Ms Edwards: Australia-wide.

Senator O'NEILL: We knew that was a data poverty site.

CHAIR: Senator O'Neill, I am conscious that Senator Siewert needs to ask a few questions.

Senator O'NEILL: Can I ask one question about the North Coast, before we move on to some other things? As a senator for New South Wales I am very interested—I have visited pretty much all of these trial sites myself in the course of the previous parliament—in the decision on the North Coast to spread the resources across a significant number of different areas, which was of concern to me. All of the communities are in need, but I note here in your update that the PHN has expanded the trial to now also include the Bellingen LGA. Do you have any concerns about how thinly the money that's been allocated is being spent in particular trial sites?

Ms Edwards: We know that activities will always want more investment, but at the end of the day, as Ms Da Rocha says, we are actually empowering community organisations through the PHN to decide how they want to do this. I would be loath from here to start telling them that they haven't made the right decisions there. That's why we're evaluating it, to help, and that's why we'd provide advice if asked, and in terms of liaison meetings about what might be tried here. At the end of the day, we are really trusting communities to tell us what's going on in their communities and how they might address the issues where they are. If that's the decision they've made in that area, we're keen to support them in that, and then to find out whether that's had a big impact and whether we can learn from that, to try and expand elsewhere.

Senator O'NEILL: We all understand how each community is very different. I live in regional New South Wales; it's only an hour and a half north of Sydney but it's a very different community from an inner-city community and requires a completely different set of responses. Ms Edwards, I'm sure you are still aware of concerns, though, that a differentiated response does not necessarily mean an excellent response. What is the department doing to make sure best practice is embedded in the innovations at local level, because we don't want to be starting from scratch everywhere?

Ms Edwards: That's why they're being led by the PHNs, who are the local experts on this area and bring together experts in the area, the data and so on. We provide information and support as required through the PHNs. The design of this is to get close to the ground and to think about what communities need. We are often criticised for having a one-size-fits-all, and telling people how to do it—

Senator O'NEILL: Absolutely; best practice, informed local application.

Ms Edwards: Absolutely.

Senator O'NEILL: How can I be confident that these communities are actually receiving best practice, informed data to create their local responses?

Ms Edwards: We can be confident that they've got access to all of the information, but at the end of the day these are trials where we're trying new approaches that are very embedded
and have been consulted on with the community, based on the evidence available, in order to learn how we might address this really difficult issue. If we knew what to do, we would already be doing it.

Ms Beauchamp: This is complementary, in terms of the national suicide trials, to a number of other trial sites that have been initiated through state and territory governments. In total there are about 29 trial sites across the country. The Black Dog Institute is absolutely trying to bring the learnings from all of these trial sites together around developing what is best practice at the local level—what works and what doesn't work. A lot of sharing is going on across all of those trial sites, and indeed across the PHNs, in terms of what works and what doesn't work.

Senator O'NEILL: Is that by anecdotal report or by evaluation?

Ms Beauchamp: No, it's actually evidence based, and that's why Black Dog Institute have actually been employed to do the work. Funding has been provided by not just the Commonwealth but the states and territories where these trial sites are operating, to look at the evaluation framework that you're talking about and at how we collect information that we know is going to lead to a reduction in suicide rates. When you look at the documents that have been brought together and the information around the trial sites—four years does sound like a long time, but when you're looking at activities being put in place and the different models—that actually is a good framework that's going to give us valuable information in terms of going forward. I might be able to get my hands on that document and provide it.

Mr Roddam: In terms of the amount of funding we have provided to the Black Dog Institute, that's the third stream of funding. There is the direct funding to the sites, as I said before, and funding for the evaluation for the University of Melbourne. There is also $3.4 million over four years to the Black Dog Institute to provide support to the trial sites.

CHAIR: I will ask Senator Siewert to ask a few questions, but in about 15 minutes, before the break, the NHMRC will come back.

Senator SIEWERT: I've got some questions for the commission to start off with. I wanted to ask about the Mental Health Commission's 2019 National Report into Mental Health and Suicide Prevention and ask why LGBTIQ+ people haven't been included in the report, given they were identified as an at-risk group in 2018. And I doubt very much that that situation has changed in the last 12 months.

Ms Morgan: Thank you for that question. Whilst in the 2019 national report there may not be specific mention of demographic groups or groups such as LGBTIQ, firstly it does not mean that they are not included in our considerations. But perhaps the best way I can answer your question is to focus on the approach we took with the national report. That is our opportunity to have a look at mental health reform across the nation. There are a plethora of areas that we can go. What we chose this year was to concentrate on three significant areas, being the PHNs, the NDIS and—

Ms Edwards: Social determinants of health.

Ms Morgan: We chose those particular areas to actually focus on. Embedded in each of those are particular needs of particular groups.
Senator SIEWERT: There is still no reference, as I can tell, in the report to LGBTIQ+ community members. Again, I ask: how then do you identify specific strategies that specifically support different cohorts of people, including LGBTIQ+ people?

Ms Morgan: In terms of the report, they make broad recommendations that would direct certain activities to be done. The report does not go down to specific initiatives to be looked at. Probably the most important role of the commission is to monitor and report on what is being done, to provide policy advice, but not to specifically direct initiatives that should be undertaken. We certainly take the point. We would agree that a priority area is LGBTIQ. And when we monitor and when we report on activities that are being undertaken, for instance, by the PHNs, it would be noted by us whether there were specific programs or not that were included. But we don't direct.

Senator SIEWERT: Swap your hats! In terms of the vision for 2030 and inclusiveness of LGBTIQ+ communities, have you got a plan for outreach to LGBTIQ communities?

Ms Morgan: Absolutely. When we look at the 2030 vision—can I make a distinction between a 'vision' and then a 'roadmap' and then a 'plan'—I think they are clearly three different things. The vision we are looking at is to say, 'If you have a mental health and suicide prevention system that is providing to the needs of any Australian at risk of mental health or suicide risk, then what is the structure, the systemic structure, that you need?' The roadmap is the policy touch points, the funding touch points, the system design initiatives you need to do. And the plan is the investment and the activities that you would undertake—and very much so in terms of the consultation we have had around the country, the needs of LGBTIQ people are going to be a key focus. What that will mean is ensuring that, as we design the system, it is a system that can be accessed by that group as well as by any other group of Australians.

Senator SIEWERT: In terms of when you are engaged, talking to people, you will be reaching out specifically to LGBTI groups around Australia?

Ms Morgan: We not only will, but we have done. It is very important to us that we do that.

Senator SIEWERT: Would you take on notice the groups that you have reached out to overall to date and the groups that you plan to? Is that possible?

Ms Morgan: It is. I don't have the information here today.

Senator SIEWERT: Take that on notice, I beg your pardon. I didn't expect you to be able to rattle it off. If you could take that on notice, that would be very much appreciated.

Ms Morgan: I will. In terms of the consultation, we had at our town hall consultations over 1,060 people. We met with an additional 100 stakeholders and we had over 2,200 responses to our survey. So embedded in that is a significant number. We will bring back to you what information we can.

Senator SIEWERT: Thank you very much. That would be much appreciated.

CHAIR: Can I jump in there, just while you are taking those questions on notice, we did ask earlier, Ms Morgan, about your visits to communities or Aboriginal and Torres Strait Islander organisations. Are you able to provide that as well to the committee?
Ms Morgan: I certainly can. In terms of specific organisations, I will have to provide that information. But the approach that we took when we were doing the consultation was to go into 26 communities around Australia. We focused on what we called town hall meetings, which was our way of representing that we wanted to meet with people in community. And we had some stakeholder engagement in addition to that. Of the 26 communities that we visited, in nearly every one, I think it would be fair to say, we touched with Indigenous people. We also had some specific communities. The places that we visited were Thursday Island, Palmerston, Nhulunbuy, Kununurra, Kalgoorlie, Geraldton, Perth, Mount Isa, Townsville, Brisbane and Gold Coast, Armidale, Bathurst, Broken Hill, Wollongong, Albury-Wodonga, Bendigo, Melbourne, Dandenong, Safety Beach, Launceston, Hobart, Adelaide and Port Lincoln. I've also had opportunity to travel to the Kimberleys and I have met with groups such as Red Dust and have engaged with individuals from the Indigenous community as well. In terms of names of organisations, I will need to take that on notice.

Senator SIEWERT: I think it is largely the department that I should be asking these questions of. I'm after more detailed responses to our inquiry into regional and remote mental health services. I note the government's quick response to the report. However I'm after a more detailed follow-up on the report. First off, it is pleasing to see the government supported a number of the recommendations. For example—

Ms Morgan: Fifteen.

Senator SIEWERT: And notes three and supports the intent of one. Can I go to the rural and regional mental health strategy—and I note that that was supported—and ask where the process is up to for the development of that particular strategy?

Mr Roddam: That is a strategy we are considering in light of the advice that's about to come from the Productivity Commission next week in terms of its draft report as well and also the workforce strategy that we are talking with stakeholders and the Mental Health Commission about a lot as well. We are still considering the best way to give effect to that strategy through these various pieces of work and inquiries that are going on at the moment.

Senator SIEWERT: What is the time line like? You just said you're waiting for the Productivity Commission report. I take that on board. But what happens after that? I would like the commission to add to that, if you've got anything to add.

Mr Roddam: There's no firm time frame at the moment but we will consider that in light of reports such as from the Productivity Commission. So perhaps by next estimates we will have that.

Senator SIEWERT: And the workforce issues, did you say?

Mr Roddam: There is a workforce strategy being developed as well. Obviously that workforce is a key issue in rural and remote areas; so that will need to consider the work of that inquiry as well.

Senator SIEWERT: Did you have anything to add?

Ms Morgan: No. Perhaps the only appropriate thing to add there is that again, in the vision work we are doing, that is for the whole of Australia.

Senator SIEWERT: I noticed you said a number of regional centres.
Ms Morgan: It is a key focus for us to be able to say again the vision provides the underpinning structural framework for what we need to do. Overlaid across that will be the investment plan and the initiatives and the workforce development strategy that we're working closely with the department to develop. I would support the observation that workforce capacity is a key issue.

Senator SIEWERT: Obviously that was identified in the report, which is where I wanted to come to and touch base on where that is up to.

Mr Roddam: The workforce strategy?

Senator SIEWERT: The workforce strategy, yes.

Mr Roddam: We are about to commence work on that through an expert advisory committee, which will be independent and will provide us with advice on that strategy. Again, we don't have a firm time frame or final date for the development of that strategy, but that's getting underway very soon.

Senator SIEWERT: Will we be able to get a further update on that in terms of when we can expect it by?

Mr Roddam: Yes, certainly by next estimates the committee that we are setting up will have met and we will have, I think, an idea on time frames on the strategy by the time of next estimates.

Senator SIEWERT: If I can find this elsewhere, tell me where to find it. Who is on the expert panel?

Mr Roddam: I think we have the list.

Senator SIEWERT: Do you have a list—

Mr Roddam: I know it is being co-chaired by Mr Tom Bryson and Miss Jennifer Taylor.

Senator SIEWERT: Is there a list you could table before the end of today?

Mr Roddam: Sure, we will do that. In fact, I may have it now. Sorry, we will get back with that.

Senator SIEWERT: If you could table it today, that would be very much appreciated. In terms of the recommendations, I wanted to go to the recommendations around the emotional, social and wellbeing strategy and ask for an update on where that is up to—recommendations 10 and 11. 'We recommended that the Commonwealth Government prioritise the development and implementation of evaluation plans for the National strategic framework for Aboriginal and Torres Strait Islander peoples' mental health and social and emotional wellbeing'. Where is that up to? The government supported that but that's been on the books now for quite some time and we're still not seeing it adequately implemented, let alone evaluated.

Ms Edwards: We might have to take that one on notice, because we're not sure we have got the right information here.

Senator SIEWERT: Could you take that for both recommendation 10 and also the recommendation that we made around the PHNs—or are you able to provide that information?

Mr Roddam: No, we would need to take that on notice.

Senator SIEWERT: If you could take that on notice that would be appreciated.
CHAIR: Senator Siewert, I just need to interrupt briefly. We had an undertaking earlier to bring the National Health and Medical Research Council back to the table; so we need to bring them back before the break if that was okay and we will come back to you straight after the break.

Senator SIEWERT: Okay.

Ms Edwards: I also have an answer to Senator O'Neill's question earlier about the breakdown in funding between mechanisms of choosing grants in the NRMF. Did you want me to provide that now?

CHAIR: If you have that, Senator O'Neill will be very happy to hear that, I'm sure.

Ms Edwards: We've put this together so the numbers are slightly approximate because we've done it this afternoon quickly for you, but it is approximately $200 million through the full-blown competitive process we talked about. There's about $61 million, which is through the rapid applied research translation centres, which are the competitive processes run by the NHMRC, which we tag onto; $45 million for the BioMedTech Horizons program, which is done as a competitive round through the department of industry. They are along the spectrum we were talking about. They are not the full competitive rounds run by the NRMF but they are tagging onto other competitive rounds.

In relation to other funding, there is $5 million for the Australian Clinical Trials Alliance to target what is seen as the need to get clinical trials advanced; $35 million for the Telethon Kids Institute for the development of a Strep A vaccine for the prevention of rheumatic heart disease; and $25 million for the Juvenile Diabetes Research Foundation to support research projects. Those are the key items; that's the breakdown. Adding up the rheumatic heart disease and the juvenile diabetes, that is $60 million plus $5 million to clinical trials, and then there's 106-ish which goes to those competitive processes run by the NHMRC or the department of industry that we have tagged onto, and $200 million for fully competitive rounds of ours. We will take it on notice to break it down for you more and to give you numbers to the dollar—

Senator O'NEILL: So fully competitive, then hybrid competitive—if you could name those different elements of it.

Ms Edwards: Yes; we will provide that. I wanted to give you a sense of the breakdown today.

Senator O'NEILL: And the total quantum?

Ms Edwards: It is about $570 million with 74 per cent of grants—not the amount of dollars—to competitive and 26 per cent to other. We will provide that when we reply on notice.

Mr Roddam: The proportional breakdown is by number of grants, not by dollars spent.

Senator O'NEILL: I want dollars spent as well.

Mr Roddam: Yes, I know, which will be a different proportion.

CHAIR: We'll now ask the National Health and Medical Research Council to return to the table briefly. Senator Steele-John has some questions for them as well.

Senator O'NEILL: When we last talked, we had confirmed that 'Sapphire' was the name of the new grants management service. I was pointing out that I've got in front of me CN3448150, with an original contract value of $2,268,858. Is that correct?
Mr Krizan: Senator, you are correct. There were two components to that original contract. The amount that you described was for development and implementation of the system; standing it up.

Senator O'NEILL: Excellent. The contract, if I read this document correctly, appears to have been amended eight times: in June 2018, in October 2018, in November 2018, in July 2019, in August 2019, again in August 2019, in September 2019 and an additional time in September 2019. Can you explain that to me?

Mr Krizan: I can. The NHMRC is developing a solution that draws on a range of technologies. There have been a number of changes in the design as we've gone along. We tend to operate, for want of a better term, on a somewhat agile basis, which means that we tend to develop up certain capabilities, prove them and then move on to the next level of purchase.

Senator O'NEILL: There is a lot of purchasing going on, by the looks of things.

Mr Krizan: In terms of IT systems, these are not particularly large amounts; it is just that there were a number of variations. That explains why there are a number of contributions to that total amount.

Senator O'NEILL: Words you have used are 'design change' and 'on an agile basis'. If I look at the most recent contract amendment notice, it appears now to be valued at $13 million.

Mr Krizan: That is correct. There are two components. We use a suite of technologies with a couple of vendors; it's not a single vendor. As at July the total was $15.9 million of contracts that we had let. Since then we've let out another $300,000 or so because we've gone through systems integration between the various technologies so we could deploy Sapphire. It was deployed today. It is accepting grants through the new system in a pilot scheme.

Senator O'NEILL: There is an extraordinary difference between the original $2 million cost to taxpayers and now a cost of $13 million. How did that happen?

Mr Krizan: The first contract's total value was $5.8 million because it included an operational component.

Senator O'NEILL: So it has only doubled, is what you are telling me?

Mr Krizan: No, I am not saying that. I acknowledge that a lot of money is being spent in terms of the original plan for a spend of about $5.8 million, but since then the expectations of the NHMRC have grown dramatically and the design has changed. Some of that is as we seek to develop capability that can into the future better accommodate supporting the Medical Research Future Fund, and some of it is because we have always provided grant services to other organisations. The changes reflect that this, rather than being a project, is a product that we are developing and that is changing over time.

Senator O'NEILL: Are you building a Rolls Royce, Mr Krizan?

Mr Krizan: No. We work on minimum viable products. Once we prove something, we then take it to the next level. In terms of systems builds, I could put to you that $16 million is a relatively modest amount for the complexity of trying to support peer review and trying to support not only our own organisation but other organisations such as the Department of Health into the future.
Senator O'NEILL: Did the NHMRC seek any legal advice on any of these eight contracts at any stage?

Mr Krizan: Absolutely. At every step we draw on government panels. When you draw on government panels, a procurement is classified as an open tender. In addition, we have had intimate engagement with not only our internal lawyers, but we have an independent expert lawyer in this area and we engage them in every area of our procurement.

Senator O'NEILL: How much does that legal advice cost?

Mr Krizan: I don't have that level of detail with me, but I am more than happy to accept that on notice.

Senator O'NEILL: Do you cost the element for the internal advice or just external, independent—

Mr Krizan: We don't normally attribute to that level. It would be, in the scheme of things, relatively minor. It would be unusual for us to attribute our internal legal expenses over such a project.

Senator O'NEILL: If you could provide detail of the cost of the independent legal advice, the cost on that—

Mr Krizan: I certainly can.

Senator O'NEILL: Thank you. Was it provided on each occasion by the same independent expert? There had been multiple occasions on which you had sought advice.

Mr Krizan: We have used the same lawyers throughout the process.

Senator O'NEILL: If you could identify that, that would also be appreciated.

Mr Krizan: I can.

Senator O'NEILL: Thank you. With regard to the scale of the expenditure, $11 million was what I was working on when I prepared for this. You've confirmed for me that it's now $16 million—$15.9 million, to be correct.

Mr Krizan: That's correct—$16.2 million is the latest.

Senator O'NEILL: So $16.2 million, because of the additional $300,000 you have just identified.

Mr Krizan: Yes, that's right.

Senator O'NEILL: So $16.2 million, that's in the order of a 600 per cent increase in the cost.

Mr Krizan: As I said, the difference between a project and product is vastly different. The expectations of NHMRC have changed, including the fact that we did receive additional funding from the government to stand up as part of this project, some advanced analytics technologies that help us accelerate some of our internal processes and also to help accelerate reporting on the outcomes of research. This is pretty complicated new work and that was as a result of a decision from government to help us stand up a more contemporary system that can better support our own needs and the needs of others. That's one of the main things that has contributed to the increase in the price.

Senator O'NEILL: Who was the relevant minister at the time these decisions were undertaken?
Mr Krizan: Are you talking about the health minister?

Senator O'NEILL: On all occasions it has been Mr Hunt who has approved these? I want to be clear about that.

Mr Krizan: The minister is kept aware of major developments, including our IT system. The minister is not involved in any approval processes for this project.

Senator O'NEILL: I'll ask you clearly and cleanly: did the minister sign off on these contracts or any of the amendments of the contracts?

Mr Krizan: No, that's an internal delegation and it is signed off within the NHMRC.

Senator O'NEILL: Was the minister briefed on the original contract or any of the eight subsequent amendments to the contract? There must be nine now, because you have this $300,000.

Mr Krizan: There are considerably more because they are done in small chunks. And no, we brief the minister periodically but we certainly don't brief the minister on every minor variation that we do. We are obviously doing this in small chunks and then bringing it up to a workable level and then we move to the next phase.

Senator O'NEILL: What constitutes in your estimation, Mr Krizan, a 'minor variation'?

Mr Krizan: That can vary sometimes from several thousand dollars to a couple of hundred thousand dollars, and then we get into more significant, where there could be a signature for a couple of million dollars if we are extending to the next level of capability.

Senator O'NEILL: So at what level does a sum trigger an announcement of what you are intending to do to the minister? Is there any point at which you think it's important enough to advise the minister of the cost blowout?

Mr Krizan: Certainly if we felt there was a cost blowout, we would have advised the minister. At the moment, everything we do is within the visibility of the Department of Finance and we've got a very close relationship with them. The Department of Finance has signalled it has expectations of the NHMRC as a grants hub. At the moment we provide grants hub services to the Department of Health. So at this stage I wouldn't classify the project as being a cost blowout. Certainly it is a significant amount; I acknowledge that. But, rather than being a project, it is a beast that is evolving, Senator.

Senator O'NEILL: How many more millions are going to be invested in its beastliness?

Mr Krizan: Senator, we are reaching our limit for the moment and we are deploying what we can, but I'm not able to advise you on that, because it depends what further expectations are brought forward and if further resources are brought forward.

Senator O'NEILL: Some of those expectations you referred to, if I heard you correctly, refer to requests from the Department of Finance, anticipating that they want to use that as well.

Mr Krizan: Simply, there is a dialogue; I wouldn't call it a request. There is a dialogue as part of the Streamlining Government Grants Administration Program that is within the Department of Finance. There is a dialogue around the expectations of the NHMRC. That's an evolving dialogue, and I couldn't say to you that it's clear now what exactly is expected, other than the Department of Finance supports NHMRC in providing grants hub services to the
Department of Health at this stage. There may be a possibility for further support beyond Health into the future, but that at the moment is speculative.

**Senator O'NEILL:** Are any other departments—we're talking Health and Finance there—involved in the dialogue?

**Mr Krizan:** Not in relation to the development of Sapphire; no.

**Senator O'NEILL:** Was the minister at any point briefed on the significant cost blowout?

**Mr Krizan:** Again, we have kept the minister appraised broadly around the Sapphire development, but this comes under the purview of the CEO's departmental expenses. We wouldn't normally be drawing something like this to the minister's attention because at the moment it's not particularly outside of expectations. We are developing a system in phases as we can bring to bear resources, and the main time we would inform the minister, and more widely, is if there were some sort of problem or risk to government or risk to the organisation, and that doesn't exist at this stage.

**Senator O'NEILL:** Could you give me an indication in the management of this contract what briefs were provided to the minister about your progress?

**Mr Krizan:** I would have to go back. There have been probably four or five, but I would have to take that on notice.

**Senator O'NEILL:** If you could provide as much detail as you can about the briefing that went to the minister and if you could provide a copy of the briefing, that would be appreciated.

**Mr Krizan:** We can certainly do that. You will find that it is a quite cursory briefing. As I said, the minister doesn't usually get involved in matters of departmental administration. That is the CEO's purview.

**Senator Colbeck:** We will take that notice. We may not be able to provide a copy of the brief, but we will take that on notice.

**Senator O'NEILL:** But it's a cursory brief anyway.

**Senator Colbeck:** As you would understand, it is advice to government. It might be that we can advise you of, say, the times of advice to government. But I will take on notice the provision of a brief because that's the appropriate process.

**CHAIR:** I draw your attention to the fact that we were going to break at four, but we will keep going, if you like. I know Senator Steele-John had a few questions as well for the NHMRC. So if we can just keep going?

**Senator O'NEILL:** Thank you. You're going to advise me on how many times the minister was updated on project Sapphire?

**Prof. Kelso:** I wonder whether it would be helpful just very briefly to explain what Sapphire is so that the significance of it is a little clearer? If that's not useful then I certainly won't waste your time.

**Senator O'NEILL:** We're just on a tight time line. Perhaps if you could give me that fulsomely in writing, that would be very helpful. Thank you.

**Prof. Kelso:** With pleasure.
Senator O'NEILL: I'm not quite sure if this is appropriate, given the evidence you've given, but is the project complete?

Mr Krizan: No, it's a multi-year project. As I said, it's more than a project; it is a product. It is a program of work that will evolve over time. Our current system went through the same experience.

Senator O'NEILL: So it won't be completed; it will be a continuing work in progress?

Mr Krizan: It will be for the immediate future, the next 12 to 18 months.

Senator O'NEILL: Do you expect further expenditures in that period of time?

Mr Krizan: That's possible, but I wouldn't like to speculate. There are a number of decisions that need to be made in terms of where and how far we go with the system.

Senator O'NEILL: What would be the key factors that would determine such decision-making?

Mr Krizan: That would be a range of things, including available budget at the time and the functionality that we are able to deliver to the health and medical research sector using not only our existing system, which remains functional—although it's getting older—but also the new technologies.

Senator O'NEILL: You mention that there's a pilot underway for receiving—

Prof. Kelso: Maybe it would be helpful for me to explain very briefly that this is the system that runs all of our grants processes, so it's a system through which applicants all around the country submit grant applications. It's the system through which we then allocate grants out to expert reviewers around the country and internationally to enable them to undertake peer review of our grant applications. It's the system that manages the processes when we draw together grant review panels. It's the system that manages the award of grants and then all the post-award management of grants. In any one year—

Senator O'NEILL: Is there a special spot for the minister to come in and override? We've seen that before.

Prof. Kelso: To date that has not happened with the NHMRC. We receive about 5,000 grant applications a year. We have 4,000 grants active at any one time. So this is a core workhorse for NHMRC. It's an essential system. We have a current system called the Research Grants Management System, which is now on its last legs, and we've been working as fast as we can and with the resources available to replace it with a 21st-century system, which is Sapphire. It's absolutely essential. We're rolling it out in phases as resources become available. We have just opened the pilot of Sapphire for one grants scheme, development grants, so applicants can now start submitting development grant applications in the system today. Subject to the success of that pilot, we will roll the system out all through the next year in all of our other grants schemes and also in the MRFF schemes that the department asks us to run. So it's an absolutely critical piece of infrastructure that we're developing as fast as we can with the resources available, but it is inevitably complex.

Senator O'NEILL: Thank you for that; that was very brief. The pilot is engaging which particular research project?

Prof. Kelso: Development grants. Anyone around the country in a university or a medical research institute or a hospital can submit an application for funding to this scheme, which is
for proof of concept pre-commercial research towards the production of a device or a drug or a vaccine or a similar medical product.

Senator O'NEILL: The people who are submitting into that particular scheme are now submitting into Sapphire?

Prof. Kelso: It opened today, and it closes, I think, early in the new year; it might be before Christmas. They have usually about six weeks to two months to submit applications and then we will commence peer review.

Senator O'NEILL: I'm sure you'll be watching this closely.

Prof. Kelso: Indeed.

Senator O'NEILL: I will be interested in any updates you can provide in the next couple of weeks about how the initial pilot is going.

CHAIR: Senator O'Neill, I'm just conscious that Senator Steele-John still has some questions as well. Are there any that you can place on notice?

Senator O'NEILL: I've only got four left.

CHAIR: I'm very conscious of the time.

Senator O'NEILL: What's the impact of the cost of this project on the work of the NHMRC?

Prof. Kelso: Meanwhile we carry on all of our work within our resources within our departmental appropriation.

Senator O'NEILL: What's your appropriation?

Prof. Kelso: The exact figure is $37 million.

Senator O'NEILL: So $37 million per annum?

Prof. Kelso: Yes.

Mr Krizan: Yes, and we've got about $5 million in external revenue where we conduct services for other organisations, including the Department of Health.

Senator O'NEILL: The $16 million over the period from June 2018 until now is a very significant part of that budget allocation.

Prof. Kelso: Yes, it is. It does includes the modernisation fund money, which has come in in addition to our—

Senator O'NEILL: Is that the $5 million you've just referred to?

Mr Krizan: No. The modernisation funding was $8.49 million over three years.

Senator O'NEILL: Thank you very much. Have any staff within the NHMRC been allocated to work on this project? How many are working on it and how many do you think have worked on it over the course of its delivery so far?

Prof. Kelso: We will provide that information on notice, if we may. It involves people across the organisation because there has to be very close integration between our grants teams and the IT teams and then, of course, the vendor people as well. It's not a simple number, I'm afraid. We will do our best.
Senator O'NEILL: If I can have the last two live and then I'll put one on notice. Is there a backlog of work at the NHMRC as a result of the project and the cost blowout? And are your staff under additional pressure because of the dollars that this is soaking up?

Prof. Kelso: There isn't a backlog of work. We are managing our work according to the resources available. Staff are under pressure, but that's not an unusual situation.

Senator O'NEILL: What lessons have you learned from the Sapphire project in the NHMRC so far?

Prof. Kelso: The complexity of IT projects, but everybody learns that whenever they attempt to roll out a large IT project, and of course we knew that already because we've done it before. The importance of engagement with the research sector. We have a very useful reference committee of people from around the research sector and the institutions to help us use the system and tell us what they need from it. It's a very close interaction. We've learned a lot from that process. We've learned a lot about internal governance of a complex project, and I think we have a very good internal governance situation now with the project. But of course, naturally, there have been a lot of learnings from something as complex as this that is not exactly the same as IT projects were 10 or 15 years ago.

Senator O'NEILL: On notice, could I ask you to provide a table with the number of staff working on the program—part time or full time—within the NHMRC since it commenced in 2017, and if you could specify the level, whether it is APS5 or EL2 et cetera, and whether they were reallocated from within the NMHRC or brought in specially for this project. Thank you. Thanks for your patience, Chair.

CHAIR: Senator Steele-John, I'm hoping some of your questions have been asked.

Senator STEELE-JOHN: Thank you, Chair. It sounds like it might be a project that is useful to turn off and back on again, Professor Kelso. I just want to start by reflecting the absolute real joy and hope that the NHMRC have brought Australians journeying with ME/CFS in recent months, with the work that you've been doing around the grant process that was announced on 22 October. I've got a couple of questions around that. But just before I get into that, just a quick point of clarification. The media release put out by Minister Hunt on the 22nd referenced funding for chronic fatigue syndrome, but the substantive nature of the release mentioned ME/CFS. Can I clarify—because they are obviously two different things—that the funding is for myalgic encephalomyelitis and chronic fatigue, not chronic fatigue generally?

Prof. Kelso: Yes, it is certainly for ME/CFS.

Senator STEELE-JOHN: Fantastic. That is really useful to note. As you are aware, Professor Kelso, because I know former Senator Ludlam and I have been talking to you about this issue for a long time, there is a real awareness within the medical research in this space that things such as graded exercise therapy and cognitive behavioural therapy are not only not useful approaches in relation to this condition but also quite damaging to individuals who journey with it. Could you give me an idea of what processes or guidelines have been put in place around the delivery of this grant funding to ensure that it doesn't go to projects that look at graded exercise therapy or cognitive behavioural therapy?

Prof. Kelso: The focus of the targeted call for research is on the pathophysiology of ME/CFS—in other words, the underlying causes and approaches to diagnosis. The purpose is...
to focus on causes and diagnosis rather than possible treatments. I hope that reassures you and the community.

Senator STEELE-JOHN: Given that focus then, it wouldn't go within the same universe, really, as those two approaches because they are suggested, though debunked, ways of solving the condition rather than identifying the pathology of it, which seems to be the target of the research. How many applications for that grant funding have you received to date?

Prof. Kelso: We haven't received any because the call for applications opened today.

Senator STEELE-JOHN: Opened today?

Prof. Kelso: It is indeed a big day for us. It wasn't timed specifically for Senate estimates.

Senator STEELE-JOHN: Can you tell me whether is there anything unusual or specific around the nature of the way you have set up your grant funding structure for this that is different than you would do it usually?

Prof. Kelso: It is a classic targeted call for research in the sense that the design of the grant call is specifically for the topic that it addresses. It has a budget of $3 million, so we hope we will get a number of strong applications. We would normally expect that would allow funding of somewhere between two and four or five grants. So we look forward to seeing what we receive.

Senator STEELE-JOHN: Finally, can I get some clarification. We are focused here on the cause. There is, again, not very reputable research that talks about psychosomatic cause. Are there processes in place to screen that out, or could that potentially be the basis on which you apply for some of this money?

Prof. Kelso: The specific grant guidelines will not be seeking to exclude any particular area of research within the scope that's defined. If we're talking about causes and diagnosis, it won't be saying exactly which causes should be studied. It will then be a competitive process where the grant applications are reviewed by an expert committee and they will advise us on the relative ranking of these grants. We don't set out to exclude certain types of research. Whatever the research is, it will need to make the case and be competitive.

Senator STEELE-JOHN: So that then goes before a committee?

Prof. Kelso: Yes.

Senator STEELE-JOHN: Is the committee already established?

Prof. Kelso: As far as I know the committee is not yet established, but if it has been then I will provide that advice on notice.

Senator STEELE-JOHN: Would you be able to provide me with the membership?

Prof. Kelso: We don't identify the members of committees publicly until after the processes have finished, if at all, because we don't want applicants writing a grant to suit the particular interests of members. So it's very important as part of an open process not to do that.

Senator STEELE-JOHN: I am aware that there is quite a bit of research in Australia talking to the harm that can be done to those who journey with this condition when they are subjected to a psychosomatic based approach to their condition. You are of the medical field
of old. I presume there would be a process in place to make sure that nothing that was approved by the NHMRC could do harm to somebody involved in the research process.

Prof. Kelso: This will be a matter for the expert reviewers to advise us on, because we at NHMRC aren't expert in the wide range of medical research that we fund, which is why we rely on expert committees, and we will be very careful in the selection of members of that committee to make sure we have a breadth of expertise. Beyond that, at this stage I can't really say anything more.

Senator STEELE-JOHN: If you can provide me with any information, even going to the qualifications that you've been looking for in the selection of this committee, the more information you can provide me with, the more comfort I can provide to the community.

Prof. Kelso: I hope you will allow us to hold back on providing the sort of information that would identify members.

Senator STEELE-JOHN: Yes, of course.

Prof. Kelso: What we would often do—and I can't confirm that in this case because I don't have the details yet myself—is wait to see the nature of the applications before choosing the members of committees to ensure that we have the best possible match of expertise, and also minimise conflicts of interest, because of course you can't ask somebody who works in the laboratory next door to review a grant application.

Senator STEELE-JOHN: Yes, of course.

Prof. Kelso: For this reason panels are usually chosen after we have received applications and then we attempt to cover a broad range of appropriate expertise. In due course, but not yet, we will be able to provide you with more information.

Senator STEELE-JOHN: Thank you, Professor.

CHAIR: Thank you for coming back to the table.

Proceedings suspended from 16:16 to 16:32

CHAIR: We will continue with outcome 2. Senator Siewert was going to continue.

Senator SIEWERT: Can I go back to the rural and regional inquiry. Where we left off was: I think you took on notice the issues around the emotional and social wellbeing recommendations. Can I go through a couple more. In terms of recommendation 3—which was about the PHNs and the local community input and you start from local community when you are looking at providing services—the government's response says that:

While the PHNs vary in structure and scope, reflecting local conditions, they work to a shared PHN program performance and quality framework. The first report is due to be finalised in the last quarter of 2019.

I'm just wondering is that on target and whether that is actually going to be available. Is there any possible update at this stage?

Ms Edwards: We've got a partial answer, I think. I think it is true to say we haven't prepared for these questions; so we haven't gone through the recommendations. We will take on notice to respond properly but the officer from the relevant area is here.

Ms Claremont: I am just going to tell you a little bit about the PHN program performance and quality framework. PHNs are reporting under that for the first time during 2018-19, and their reports were due to the department on 30 September; so the department would be
analysing those reports now. Nothing would be ready to report about, but those 31 PHNs would have reported under that framework for the first time through their 12-month performance reports.

**Senator SIEWERT:** Do you have a proposed release date of when that will be available?

**Ms Claremont:** To be honest, we could take that on notice because there's a range of schedules that they will report under. And it's the first time that the PHNs are reporting that way. The department will look at the range of schedules and performance reports.

**Senator SIEWERT:** I beg your pardon?

**Ms Claremont:** The department will have to look at the range of schedules and performance reports for the first time as well; so it's a little bit hard to put an exact timeframe on it.

**Senator SIEWERT:** You've actually touched on an area that I particularly wanted to go to anyway, which is how the PHNs are actually implementing a number of their programs for which they have got funding for mental health. Will that be included in that evaluation report, specifically around various mental health funding?

**Ms Claremont:** Yes. PHNs provide an activity work plan earlier in the year to map out what they plan to do, and against that they will have a range of activities that they will report against. In relation to the framework that we were mentioning before, there's a range of indicators; so they will report against those indicators. Some of those indicators will be taken from the primary mental health minimum dataset. Those will be collected separately.

**Senator SIEWERT:** Can I go and find the framework?

**Ms Claremont:** Yes. It's on the department's website.

**Senator SIEWERT:** If I just go to the department—

**Ms Claremont:** We can provide the link to it.

**Senator SIEWERT:** If you could, that would be great. One other question, which I don't think is about evaluation but it does relate to another evaluation specific to PHNs: you will be aware in the report one of the issues that came up repeatedly was short-term funding. The government subsequently announced longer term funding. Is that for all mental health programs now? There was some concern expressed to me that because of some of the funding still depending on one-year funding rollout, the performance framework—

**Ms Edwards:** You are talking about the three-year rolling funding of PHNs which we have moved to on all but one schedule, and we are moving towards the core one. That applies to all the funding, as far as I'm aware. But of course what's in that funding will depend from time to time on decisions of government and so on, but the idea is to have all of the schedules rolling forward.

**Ms Claremont:** What it does is: there are three years of funding and then, based on satisfactory performance, PHNs may qualify for an additional year. They would always nearly have three years of certainty in terms of funding.

**Senator SIEWERT:** Thank you for clarifying that. The extra year comes off the end of their two years?
Ms Edwards: They've always got three years, but the caveat would be what is being delivered through a PHN might be changed depending on decisions of government over time, but you should always have three years ahead of you in order to do the contract security, as was recommended.

Senator SIEWERT: That will be the same for any funding that is provided to them now?

Ms Edwards: That is our aim. That's where we are moving towards, yes.

Senator SIEWERT: When are we going to get there?

Ms Edwards: There is one schedule left that we haven't moved to. Actually we haven't got the PHN people here right now because we are the mental health people; so we haven't got the schedule.

Senator SIEWERT: I appreciate that, but PHNs and—

Ms Edwards: It might be that a mental health funding person will appear next to me in a minute.

Senator SIEWERT: I can ask that later. I'm specifically focused at the moment on mental health.

Ms Edwards: Mental health has already moved onto that arrangement.

Ms Claremont: And so has their core schedule. That is the beginning schedule, the first ever schedule, that has moved to the three-year year rolling arrangement, and so has the main mental health schedule as well.

Senator SIEWERT: Other than their specific programs, for example transition to NDIS, which I will ask NDIA about tomorrow—actually, I need to ask you about that as well.

Ms Edwards: I did prepare for that one.

Senator SIEWERT: Can I go to that then, while we are there?

Senator O'NEILL: Just before you jump off, can I ask a clarifying question. The PHN gets the money for three years. Then they allocate the funding to other entities to deliver projects. Do people who are then contracted to do the work by the PHN have the security of three years funding for provision of mental health services?

Ms Edwards: The answer is not necessarily.

Senator O'NEILL: That's what I heard.

Ms Edwards: It depends on what they're commissioning and it also depends on the strength of the commissioning service about whether you want to be careful how it's delivering. So there might be all sorts of reasons why you give them a longer or shorter contract, but that's the decision that the PHN makes in the course of the commissioning process.

Senator O'NEILL: On the ground, what that means is people who have a service provider—and you know for mental health, continuity of service provision is a critical part of the quality of delivery of service—the PHN are getting the money for the three years, which is a good start, but they are not given that funding certainty to the providers of the actual service who are the faces and the talent and skilled people who are interacting with the ordinary Australians who are seeking those services.
Ms Edwards: They might be in some instances but there might be all sorts of the reasons why in the course of the commissioning it wouldn't be appropriate to give it for three years.

Senator O'NEILL: Yes, but in most of the instances you'd hope that they have robust processes, or they wouldn't give it to anybody. What I'm hearing is that people who are providing the service are facing the same challenges that were articulated and that lead to the funding of the PHN, which is uncertainty of contract provision to the providers of services. And this is diabolically bad in regional and remote contexts.

Ms Edwards: Mr Cotterell might want to comment, but we may have to take some of this on notice because, obviously, we need to go back and investigate what the PHNs are doing in order to assess and provide you with information about where that is the case or not the case and why. Did you want to comment?

Mr Cotterell: As Ms Edwards said, it's up to the individual PHN to go through their commissioning process and determine the length of the contract according to a risk framework that they might have in place. But if there are instances in which that is resulting in adverse outcomes like you have described, we would be interested in hearing about them so that we can talk to that PHN and find out what happened and, if necessary, correct it.

Senator O'NEILL: Can you provide on notice your auditing of the current status of the services that are being provided by PHN to see how many of the service providers they are actually giving funding certainty to? The worst outcome would be that the PHN gets a certainty or funding for three years and that the people delivering it don't actually have any certainty. The goal was to provide certainty of service provision and continuity of service access to the same service provider wherever possible. I thought that was a policy outcome.

Ms Edwards: We certainly should take it on notice. There are 2,900 contracts the PHNs have; so I would be loathe to commit to providing all of that on notice. If we provide you some detail about the manner, or if there are any particular instances you are concerned about, if you provide it to the department we'd investigate those.

Senator O'NEILL: I can provide you with some, but we can't be the auditor of this process. We need confidence that there is no hoarding of that money for three years by the PHN and insecurity.

Ms Edwards: I appreciate the question but I'm just not sure that providing the detail of 2,900 contracts is the best way to provide the information to you. We could take it on notice. We understand the question. It's about: are PHNs appropriately passing on funding security for the services they provide, particularly in relation to mental health? And we can undertake to investigate anything you might provide us through the minister's office or through the committee and also to provide a general answer and to go to your question, which we understand and we share the concern.

Senator SIEWERT: Would that be picked up in the performance process? Surely that would be an indicator of whether you are providing long-term funding?

Ms Beauchamp: It is part of the commissioning project. And when you have a look at the principles and what's required of PHNs in terms of commissioning you get concerned about funding certainty for a particular provider because it should be based on performance, innovation, continuity of service and outcomes for individuals on the ground. I think the PHN commissioning framework and those principles are certainly key features of the approach.
which we've developed with PwC and others to make sure that we do have an ongoing monitoring process.

**Senator SIEWERT:** That process should be built in—I appreciate that—but one of the constant refrains we hear is lack of certainty of funding. And it was a constant in this inquiry. Those sorts of things are handled in appropriate ways for all of the grants that you and DSS and all other agencies handle.

**Ms Edwards:** We've only recently moved to the three-year rolling funding for PHNs. PHNs may have given insufficient security from the point of view of service providers because we hadn't yet implemented the three years. That's why I would like to come back on notice with an explanation of where we are up to. I can assure senators that we share the concern of making sure that commissioning happens and that the appropriate service providers are given continuity. We will come back to you on notice—unless you want to add anything?

**Mr Cotterell:** The department has also commissioned a review of our grants and reporting processes with PHNs to try to make them more efficient for the PHNs and for the department—and that includes what information they are required to report and how often. I'm hoping—that process will conclude in January—that will include the length of the contracts they're putting in place with the providers, so that we will have a better handle on that. We won't have to go through 2,100 contracts.

**Senator SIEWERT:** Will that review be publicly available once it's done?

**Mr Cotterell:** We will have to brief the government on it and see if they are willing to release, but we try to be transparent about these things.

**Senator SIEWERT:** Can I go to the NDIS. Can you update us as to how the funding for transition has gone?

**Ms Edwards:** Let's start with how the transition is going in terms of how many people—I ask this particular question to give you a sense. On 1 July 2019 there were 15,484 clients of Partners in Recovery, FAMS and day-to-day living.

**Senator SIEWERT:** That's together, you mean?

**Ms Edwards:** Together; total. Then by 31 July—so after a month—there were 12,805 because people had exited to Continuity of Support because they hadn't succeeded in being eligible for the NDIS or they had exited onto the NDIS or they had exited for some other reason.

**Senator SIEWERT:** Do we know where they went?

**Ms Edwards:** Yes, we do: 673 went to the NDIS, 1,479 exited to CoS—Continuity of Support—and there 527 exits for other reasons. So that shows that we had a little under 3,000 being dealt with then. We've got a breakdown of where people are up to in the queue; I thought this is where you would be interested. Then I have some August numbers to show how we are moving through the transition. As of 31 July—I can provide these numbers later on notice, but to give a sense—there were 1,325 who had met NDIA access requirements but were awaiting to have their package. There were 2,700 waiting for an NDIA decision.

**Senator SIEWERT:** There were 1,325 who had had the package but—
Ms Edwards: They had had access agreed but they haven't moved on to the package yet, so they are still in our bucket until that's happened, and then they are counted as exited to the NDIS. There are 2,702 waiting for an access decision. They had done the application process and so on. There were 4,018 who were preparing NDIS applications. That means there were 4,560 not yet preparing an application. So those are the ones yet to enter into the process. There is a small number of 200 who are at other stages of transition. You've got to remember that there are people for whom we have no contact details; we haven't had contact with the provider for a long time. So a small number may never be found or might be very difficult to find. But it's small—200.

Senator SIEWERT: So 200 are on the books but not receiving service at the moment?

Ms Edwards: That we know of. We haven't made the conclusion they are not receiving services because we want to make sure we don't overlook anyone, but that looks likely—at least a proportion of them. Hopefully some of them are well and no longer require services. So we had 12,805 by the end of July. By the end of August a further 528 had exited to the NDIS, 736 had gone to CoS and 457 exited for other reasons. That leaves a total of 11,084 clients. That shows that about 1,000 people a month are completing the process and moving to CoS or to NDIS or something else. That puts us on track to finish this year. Although, as we go through the process, the client cohort tends to be people with more complex needs, harder to find, people who may not be well enough to go through the process, who might be in hospital and so on. We are expecting it to get more difficult, but we are pleased with the progress and we are making real investment into making sure we deal with all these people in the time available.

Senator SIEWERT: Those who have exited the process for other reasons are no longer getting any supports at all?

Ms Spencer: Clients who have exited for other reasons may be well and have chosen to exit those programs. As Ms Edwards said, some clients can't be found yet but are still on the books. The PHNs, the service providers, are still contacting those providers. So people may have chosen to leave. There has also been a tidy-up of data; for example, service providers may have had people on those books for those programs for a long time but may not have had contact for two, three or 12 months, or years. So there has been data tidy-up as well. They are the reasons. We acknowledge those people, but they are the reasons why they have exited.

Senator SIEWERT: It will take too long to go through each state, but are you able to give me on notice the state breakdown on those numbers?

Ms Edwards: I don't know. We will take it on notice. If we can, we will provide it.

Senator SIEWERT: That would be appreciated. Funding for the people who are more complex, as you have just articulated, will continue to be provided until the decision is made either way through the PHNs, the transition.

Ms Edwards: The transitional money is for a year, so we will review how we are going. That is why we are taking such close notice of how the transition is moving. Closer to the end of the year we will make another assessment of what we need to do. We are continuing to provide psycho-social supports through the PHNs for people who may never have been on any of these programs. So, whatever happens, there are always services available.

Senator SIEWERT: This is the—
Ms Edwards: It is the $80 million plus the state-matching, and the other programs we have. We're doing 1,000 a month. It is likely to slow down, but we are going to be through the bulk of this, we hope, by the end of the year. We are watching very closely. We have made a commitment that people aren't going to be without support and we take it pretty seriously.

Senator SIEWERT: You've taken over monitoring the FAMS transition as well; is that correct?

Ms Edwards: That's right.

Senator SIEWERT: So DSS aren't doing that at all now?

Ms Edwards: We are responsible for it, although we work incredibly closely with DSS and the NDIA on all this work.

Senator SIEWERT: I got some varying reports of how effective the PHNs had been, when they were engaging, particularly coming up to July. As I understand it, some providers didn't know what level of funding they were going to get and were providing support because they couldn't leave their clients. Did you get that level of feedback?

Ms Edwards: Ms Spencer can probably provide more detail—but there was, as there often is, with some of the 31 PHNs some discussions about how many clients and how much funding and so on, which we feel we resolved by the end of the year, on time. As always, some PHNs were much more on the ball, providing more than others, but we've been working hard to lift the levels all across. We have had a focus on making sure that, where possible and appropriate, those transitioning people continue to be supported through the same provider as they had before. It is not always possible, for various reasons, to provide that continuity until the testing of NDIS. Over time those services will evolve and so on, but we are trying very hard not to have abrupt changes of services, particularly for those people who are waiting to test. That is particularly important now because we know we are getting to the clients who have the most complex needs and will need the most assistance in transitioning.

Ms Spencer: I can add a bit more in relation to that. As Ms Edwards said, the PHNs did commission services at various times and speeds. Some PHNs were very quick in relation to that and others were not. But certainly we had contact with various service providers over that time where they hadn't had contact with the PHNs in a timely manner, or there were issues that were being raised in relation to that. So where there were individual issues or timing issues, we would calibrate with the PHNs to ensure that services were on the ground. By 30 June all contracts were in place and services were on the ground and transitioned.

Senator SIEWERT: I dispute that.

Ms Edwards: As always, we are very interested to hear. If that could be fed back to us about particular instances we will investigate it.

Senator SIEWERT: I think they are resolved now. There are some that I'm aware of that didn't have contracts by the end of June

Ms Edwards: We'd be surprised, given we have visibility of that. But we always welcome your information and we will consider it.

Senator SIEWERT: Is there consistency across the country in terms of the level of funding that PHNs are providing to the providers?
Ms Spencer: The allocation of funding for the transitional funding that we provided to PHNs varied. We did a modelling based on the number of expected clients in their region into the programs. Then it is weighted as well in relation to rurality and in relation to Aboriginal and Torres Strait Islanders, etc because of the expense of providing services in those areas. The decisions in relation to the funding levels to service providers are a decision for the primary health networks. That was determined on the needs for each of those clients in those regions. So it may vary—absolutely. But the PHNs would have consulted with service providers in relation to the services required.

Senator SIEWERT: Does that mean that, when the process transitioned to the PHNs, somebody may have got a different level of package or funding support than they previously got? Is that what I am to interpret from what you have just said?

Ms Spencer: That's correct; yes.

Senator SIEWERT: So they were reassessed?

Ms Spencer: The transition funding was modelled based on the clients, and we gave funding to PHNs without taking into account a transition rate over the year. Ms Edwards just ran through those numbers; there is a transition rate of about 1,000 clients per month. That funding level won't change over the year. So the funding being provided for service providers has been modelled, and PHNs has passed that on, to ensure that over the 12-month period there is sufficient funding as clients transition to either CoS or the NDIS.

Senator SIEWERT: Yes, I appreciate that. I may have misworded my question. If I've got a support through what was PIR, do I get the same level of funding through this process that I had previously?

Ms Spencer: Clients were expected to receive a similar level of support, yes. Because we don't do individualised packages per client, different people require different levels of support at different times. That might fluctuate depending on the needs of an individual at any one time. So we couldn't say 'Joe got X at a certain time.' It is dependent on what someone needed. Service providers can certainly use the funding that they have to meet the needs of individuals as those needs fluctuate, but there is not a per person rate.

Ms Edwards: What we're doing is same level service. Then we model the funding on an amount per person. But we give that as a job lot. As people exit obviously there is more money, so it will be frontloaded. We're watching closely to see how this plays out. But it's not like an NDIA package where you have an amount of money. It's about we want to provide you with that support.

Senator SIEWERT: As long as you are getting the same level of support, which is the package of supports that I am getting.

Ms Edwards: We want you to have continuity of support, obviously. When you go in to the NDIA it may be that some other different package is better for you, but we are not playing with that at the moment. We're trying to keep people stable while we do the transition.

Senator SIEWERT: Okay, thank you.

Senator McCARTHY: Minister, can you provide an update on the progress of the 30 new headspaces, the early psychosis services at selected headspaces and the digital portal, eheadspace, and the Youth Mental Health Ambassadors Project?
Senator Colbeck: I am sure the officers can help with that.

Ms Edwards: As at 16 October 2019 there are 111 headspace services operating nationally, but with the new funding provided in 2018-19 MYEFO, the 2019-20 budget and committed during the election campaign, there's a commitment to increase the total number of services to 153.

Senator McCarthy: That is 153 headspaces?

Ms Edwards: Yes, 153 in total have been committed to and we are in the course of moving towards all of those.

Senator McCarthy: So at this stage we're looking at 30 new headspaces. So in total now there are 111. Is that correct?

Ms Edwards: We were looking at 30 new services—I think that was 20 satellites and 10 centres, which was the commitment in the budget. But since then there has been additional commitment.

Mr Roddam: There were 10 new or expanded services in an election commitment as well.

Ms Edwards: So that's 40 since—

Mr Roddam: So 38—we're going from 111 currently to 145 by 2021 and then with the election commitments it was expanded to 153 by 2022.

Senator McCarthy: What about the early psychosis services at selected headspaces?

Mr Roddam: Essentially there are no new youth early psychosis services planned at this stage. The 14 headspace centres in six locations that house the youth early psychosis centres are still the case. So there's essentially the same funding in 2019-20 and 2020-21 for those services.

Senator McCarthy: So you'll have 153 headspaces by 2023 and you'll still hold onto—still only have 14 early psychosis services?

Mr Roddam: I don't think we can be definite about that, because the early psychosis youth services funding is only until the 2021 budget and there is an evaluation going on at the moment of early psychosis youth services as well.

Ms Edwards: The evaluation will provide us with information we need about where to next with EPYS.

Senator McCarthy: When is that meant to be completed?

Mr Roddam: Late 2019 or early 2020.

Senator McCarthy: And the digital portal eheadspace—sorry, the Youth Mental Health Ambassadors project and the digital portal eheadspace—just an update.

Mr Roddam: If we start with eheadspace, Senator, headspace national is currently funded $12.8 million over two years to operate eheadspace to 2020-21. In 2018-19 for eheadspace, 32,142 young people accessed online and telephone counselling through the service. A total of 82,722 services were provided.

Senator McCarthy: And the Youth Mental Health Ambassadors project?
Mr Roddam: With that project, headspace national was funded $2.8 million over five years from 2018-19 to develop that program, which will empower young Australians with a lived experience of mental health difficulty to promote mental health literacy, improve help seeking, support young people's capacity for self-care and reduce stigma associated with mental health. There are 14 young ambassadors who have personal experience with mental health difficulties who represent a cross-section of Australia's communities and backgrounds. On 25 January this year Minister Wyatt announced funding of $360,000 to extend the program to include a specific focus on Aboriginal and Torres Strait Islander youth. That's supported two additional young people to participate in the program.

Senator McCARTHY: Sixteen in total. Can I just ask how many are in the Northern Territory?

Mr Roddam: I would need to take that on notice.

Senator O'NEILL: Can you provide a distribution of where they all are?

Mr Roddam: We can do that.

Senator O'NEILL: And any detail that you can. Could I just ask a clarifying or on notice question with regard to the headspaces. Could you provide on notice exactly where the satellites are—the 10 new expanded—so the details of what is where?

Ms Edwards: Yes.

Senator O'NEILL: What's now and what's been announced—

Ms Edwards: What's coming down the line—exactly—with funding allocation?

Senator O'NEILL: Where it's been allocated.

Ms Edwards: Yes.

Senator O'NEILL: And where you anticipate the others will go if you could do that. The last thing is what evaluation has been undertaken of any of the satellite sites in terms of service provision.

Mr Roddam: We can take that on notice.

Senator O'NEILL: Do you believe there has been any evaluation?

Ms Edwards: Evaluation of the whole of the program is something we are looking at now. But there will be information about client numbers and so on of the satellite areas which might—

Senator O'NEILL: As much as you can, because definitely on my visits to those satellite sites they are simply not meeting need in a way that the real—I call them the real headspaces and the pretend headspaces because they seem to be so different in the way they offer services and availability to young people.

Ms Edwards: We'll provide the information, Senator, but, of course, we don't accept the characterisation of real and pretend. We talked about—

Senator O'NEILL: I just talked to people on the ground who want to use the service and can't get in because it's only open part-time, services are not continuous and it's not wraparound. So that's a problem. It's good to have a headspace brand, but if you're not delivering the product then it's not very authentic, is it.
Ms Edwards: One hundred and fifty-three centres nationwide of one sort or another is a huge expansion in a very rapidly expanding program, but we are interested in knowing how these are going and we hear what you say.

Senator O'NEILL: Yes. The brand is not the delivery of the product, though. Thank you.

CHAIR: We'll move on to the other areas of outcome 2 now.

Senator GRIFF: I have questions in 2.4 and 2.5, but I'd like to kick off with some questions that really kind of relate to—well, primarily palliative care is where I am going now. The 2019-20 budget statements indicated that program 2.4 included support for the provision of high-quality palliative care in Australia. Noting that there is a total of $475,631 million allocated for this program, what amount has been designated for palliative care?

Ms Edwards: For primary palliative care?

Senator GRIFF: Yes.

Ms Edwards: We can give you a rundown—you are talking about the $167 million. Is that the—

Senator GRIFF: No, actually the budget statement for program 2.4 is 475—

Ms Edwards: Yes.

Senator GRIFF: So how much of that is actually palliative care related?

Ms Edwards: Just before I hand over to my colleague, just to go back a step, obviously palliative care firstly is a large state and territory responsibility, so we are not the sole provider of palliative care services. Also, it's really important to note that a lot of palliative care is conducted by GPs out of their ordinary practices and often extremely well. So a large amount of the funding that the Commonwealth makes for Medicare payments would support palliative care. What we're talking about here is looking at what the state and territory services are, looking at what's done under MBS and then seeing how we can augment and do what is extra there.

Mr Cotterell: There are a number of lines of funding for palliative care—some within that sub-outcome and some within other sub-outcomes. It doesn't fit neatly into one outcome because of how the money is being generated.

Senator GRIFF: Okay, but you can indicate what the dollar amount would be?

Mr Cotterell: I can give you what the Commonwealth is spending. The biggest line of funding is for national palliative care projects, and that's $109.8 million over six years. Then there is specialised palliative care and advanced care planning advisory services, which is $31.5 million over six years; and the Greater Choice for At Home Palliative Care measure, which is $8.3 million over three years—it's a pilot program. Then there is some funding for hospices under the Community Health and Hospitals Program worth $15.25 million and, for Hummingbird House, $2.4 million. Then the government has a commitment of $44.8 million over five years and an additional $12.4 million in the sixth year for comprehensive palliative care in aged care.

Senator GRIFF: Okay, I am just looking at the Greater Choice for At Home Palliative Care funding. Was that $8.3 million?

Mr Cotterell: Yes.
Senator GRIFF: It was $8.3 million over the three years. In the instance of South Australia or the Adelaide PHN, they work solely with aged-care providers to deliver the pilot program and it doesn't appear that there was any at-home palliative care component of that. Is that your understanding? Would that be your understanding as well? Is that common?

Mr Cotterell: I'm not aware of the details of what is happening in the Adelaide PHN with that project, but I can give you the aims of the initiative and I can take on notice what is happening in Adelaide.

Senator GRIFF: If you could take that on notice. My interest is the percentage that's being spent towards at-home versus aged-care providers, because that seems to be an area that's very much lacking. So on notice that would be appreciated.

Ms Edwards: I would just note that, for many old people, the residential aged-care facility is their home. I hear the point, but I just wanted to make the point—and we will take on notice what is happening in South Australia—that people in aged-care facilities are really keen to make sure they can stay in their familiar surroundings comfortably and with dignity as much as anyone else.

Senator GRIFF: The World Health Assembly statement in 2014 and the document entitled the National Palliative Care Strategy 2018 recognised the holistic assessment of pain and other problems, whether psychosocial or spiritual. Are there any programs that are currently being funded that specifically address assessment and treatment of psychosocial or spiritual needs in palliative care on a federal basis?

Ms Edwards: We'll take that on notice, but I think our understanding would be that we fund for holistic care which would cover medical, pain and other needs as well as the spiritual, psychosocial and other needs a patient might have. Certainly that's our expectation of how we do this sort of funding.

Senator GRIFF: I'd now like to turn to the draft National Alcohol Strategy. I'm particularly keen if you could advise at what stage of the process the alcohol industry's input was included in the national alcohol strategy development.

Dr Studdert: Sorry, what was your question?

Senator GRIFF: At what stage was the alcohol industry involved in the development of the strategy?

Dr Studdert: There's been a long—quite long, actually, in this case—series of consultations around the strategy which has involved all relevant stakeholders, including the industry. So there's been no specific consultation directly and only with the industry. It's been all stakeholders over a number of consultations over I think probably a couple of years now.

Senator GRIFF: My interest, which you might have heard—in fact, it was a motion which you may be aware of that was passed by the Senate last week—related to the initial draft and the most recent draft. You may be aware of that. There were very significant changes by putting a positive spin on alcohol in the current draft versus the initial draft. I'm interested in how that actually happened—how it very dramatically changed between the drafts. If you look at the original one—I'll just read out a couple of sentences. Australia is referred to as having an alcohol culture where not consuming alcohol is viewed as being un-Australian. There are many Australians to whom this perception contributes to increased risk of serious harm and the development of harmful drinking patterns; accessibility of cheap...
alcohol products, social and peer pressure and exposure to alcohol in advertising and promotion and the like. That was the original. That was all taken out and replaced by a paragraph that says, 'Alcohol is an intrinsic part of Australian culture and plays a central role in most people's social lives. Research indicates that it's all about celebrating, socialising, networking, relaxing and rewarding themselves. Alcohol plays an integral role'. So you have a version that actually says that alcohol is a problem in Australia. That has been removed—two big paragraphs—and replaced by another one that says that it's intrinsic and all about relaxing and rewarding yourself. It's a very dramatic change between the two versions. I'd like to know how that happened—how one that said there needs to be caution is replaced by one that says it's important and an integral part of socialising and relaxing.

Dr Studdert: The development of a strategy like this, which is a multi-jurisdictional strategy—it's one that all the states and territories and the Commonwealth will sign up to—is an iterative process. There have been several drafts as we've gone along the way. Those do vary from draft to draft as we take on board stakeholder comments and continue to refine it through consultations with the various stakeholders, but, most importantly, ultimately among the states and territories and the Commonwealth as we work towards the final agreed text that all jurisdictions can sign up to. That's a process that is still ongoing. I think you've quoted from a couple of drafts there, but that's not the final and that process is—

Senator GRIFF: How many drafts has this gone through so far?

Ms Soper: Would you like me to take you through the process, Senator?

Senator GRIFF: Yes. I would be interested just to know at this stage how many drafts you would have—

Ms Soper: The development of this strategy has actually been around for some period of time. It started in 2015. There was a public consultation process undertaken in late 2015 which was actually looking for the kinds of things that should be involved in the strategy. There wasn't a draft at that period of time. On 27 November 2017 MDAF agreed to an additional public consultation process which ran from 11 December 2017 to 11 February 2018. That further informed the strategic direction and priorities of the strategy. Feedback from those submissions was considered by MDAF in June 2018. Generally, the majority of submissions were supportive of the key aspects of the draft strategy. The main areas which submissions focused their feedback on included the cited evidence from research, the role of industry, the strategy as a framework and the proposed target for the strategy of 10 per cent reduction. In June 2018 MDAF agreed to make submissions received during that public consultation process public. Then there was a roundtable held in July 2018 which was attended by representatives of public health organisations, research bodies as well as industry bodies. Then that draft strategy was—so the draft strategy was then updated to reflect comments and discussions that took place in that stakeholder roundtable. In September 2018 the department submitted a revised strategy to the minister's office seeking approval for circulation to the National Drug Strategy Committee. On 8 February 2019 the National Drug Strategy Committee met and discussed the draft strategy. However, a version was not agreed at that point and endorsed to be provided out to MDAF. On 27 February 2019 Ministers Hunt and Dutton, who were the Ministerial Drug and Alcohol Forum co-chairs, circulated a draft strategy to MDAF members for out-of-session consideration.

Senator GRIFF: So we're now up to four drafts?
Mr Laffan: There have been multiple iterations of this. I wouldn't say that at each of the meetings that Ms Soper has outlined there is a different draft, but there were multiple ones throughout different occasions with working groups under the National Drug Strategy Committee to bring different versions forward.

Senator Griff: My interest is simply at what point was the alcohol industry involved and at what point in this process did it dramatically change from being cautious about alcohol to actually saying it's an important part of life. I'm interested in those two, really. How did that happen?

Dr Studdert: I think as you've heard there have been multiple drafts and we would probably have to go back and look at version numbers and whatever.

Senator Griff: On notice is fine, but I'd like to—

Dr Studdert: But that change that I think you are pointing to is one that has occurred over the last couple of years. I can't quite recall between which point and which point because, as I said, there have been multiple drafts. It is also, I would note again, not the final draft, because we're not quite there yet.

Senator Griff: All right, but on notice if you could provide me when that happened—the dates of when that happened and when the alcohol industry became involved actively in this, it would be appreciated.

Dr Studdert: In order to pinpoint exactly which versions you're referencing, if you wanted to provide that information we could identify which drafts they came in.

Senator Griff: We'll do that. Just briefly on 2.5—I have a couple of brief questions relating to Health Care Homes. I understand that over 10,000 patients and 10 primary health networks have been registered under the program. Is that correct?

Ms Edwards: I think it's 9,000 and something—

Senator Griff: So close to 10,000—

Ms Edwards: It's close to 10,000.

Senator Griff: And that's 10 PHNs?

Ms Edwards: I've got the number of practices for you—or Ms Riley does.

Ms Riley: I got new figures this morning on numbers of patients and numbers of practices. At the moment—as of last night, actually—we had 126 practices and 9,641 patients.

Senator Griff: I'd like to refer to a similar Medicare advantage program in the US where medical practitioners on aggregate have been accused of overbilling taxpayers by billions of dollars with kind of a similar program. I'm interested in what audit mechanisms are in place to ensure that patients are correctly classified in the appropriate tier under Health Care Homes.

Mr Cotterell: There are two mechanisms by which we are auditing the Health Care Homes while they're in a trial. One is that we are having a look at their MBS billings alongside the Health Care Homes payments to see if the MBS billings come down, which is what you'd expect, and following up where they haven't with a closer look. The second is that we're taking a sample of patient records for the application of the screening tool and having a
medical advisor check whether the screening tool was applied appropriately—so a sample of I think 10 patients from 10 practices.

Senator GRIFF: And how is that—how are the results of that so far?

Mr Cotterell: We don't have results yet.

Senator GRIFF: It was interesting that in the US the audit of the 37 health plans found that around 40 per cent of claimed conditions couldn't be substantiated. Hopefully it's nowhere near that in Australia. That was a very interesting result. How big is the sample that you're actually auditing, did you say? I didn't write that down.

Mr Cotterell: We are looking at 10 patient records and 10 practices.

Senator GRIFF: That's a fairly low sample, of course, based on the 9,641 patients that you've—

Mr Cotterell: If there were widespread rorting we'd expect there to be large numbers of patients in the highest payment category, and that's not the case. Perhaps Ms Riley can help me with how many are in which category.

Ms Edwards: That's in addition to looking at the MBS items across the board. So if there was some sort of major pattern you would see it in that analysis and then we're doing a spot check as well. I think it's good practice.

Senator GRIFF: Thank you.

Senator STEELE-JOHN: My questions are in relation to the government response to the Senate inquiry report into thalidomide but more specifically on the health department's work in that area. I'm not sure who that is best directed to.

Ms Edwards: We'll swap out again.

Senator STEELE-JOHN: I'm making sure you get exercise during the day. Some of you may or may not know there was a Senate motion passed during the last sitting calling on the government to speed this response process up in light of the experience of survivors in waiting for this. I think Senator Colbeck would agree it was quite a bracing response that we got back from the government in regard to that, telling us to mind our own business since we'd never been in power ourselves. So in that light I'd like to really straightforwardly ask Dr Studdert where the health department is up to in coordinating the government's response to that inquiry report.

Dr Studdert: As you know, this is something we've had some engagement with you on and the committee over multiple hearings and something that we are very intent on replying to as comprehensively and as efficiently as we can.

Senator STEELE-JOHN: We needed date, Doctor. Give us a date.

Dr Studdert: I'm not in a position to give that to you, because, as you know, ultimately this is a matter for the government to respond to. We are providing advice to the minister and the government and we are in the process of finalising that. It is advice that we have to consult with other departments on, so it does take a bit of a process.

Senator STEELE-JOHN: Lovely. I'll pause you there and just go to the minister. Minister, give us a date.

Senator Colbeck: Until we receive advice, we can't provide—
Senator O'NEILL: You've just been provided with advice.

Dr Studdert: We are working on that.

Senator Colbeck: Actually, that's not correct, Senator O'Neill. The department is still working on advice and, as you just heard, coordinating with other departments. There are a range of things that we are considering as part of that process. Once the advice is finalised then the minister can consider it. In that context, it's not possible to give you a date, as much as you might like one.

Senator STEELE-JOHN: All right. We'll try it a different way then. What stage is the advice at within the department—how long before you expect to be able to give it to the minister?

Dr Studdert: I would be a bit hesitant to put a specific timeframe on it, because it does depend on variables that are not entirely within our control. But we are working, I promise you, on a very diligent, daily basis to progress that. The minister is keen to get it as well, so we will be doing it as fast as we can.

Senator Colbeck: My advice from the minister is that he'd like to get it done very soon.

Senator STEELE-JOHN: I would hope so. Of the elements that are within your purview, what stage is that work at?

Dr Studdert: We certainly have a draft document that we are working on finalising.

Senator STEELE-JOHN: Health has a draft document of the parts that relate to health or of the parts—

Dr Studdert: Of all the responses, but still in discussion with others around the final details that will be included in that.

Ms Beauchamp: The department is coordinating a whole-of-government response. Some of the recommendations actually go to financial support, as you would appreciate, and special arrangements around NDIS. As you would appreciate, our funding arrangements and financial considerations need to go through a proper budget process within government. So that does take additional time if we're looking at those sorts of considerations and a considered government response. So, as the minister said, I know Minister Hunt wants to get it done as soon as possible and has been meeting with groups of recent times.

Senator STEELE-JOHN: I know. So you're coordinating the response. The response requires interaction with Finance, for instance, due to elements around remuneration and redress. How many different departments are involved or have been required to provide responses?

Ms Soper: We've got four altogether.

Senator STEELE-JOHN: Which departments are those?

Ms Soper: We're working with the Department of Social Services, the Department of Human Services, the National Disability Insurance Agency and the Department of the Prime Minister and Cabinet.

Senator STEELE-JOHN: Of those four, how many, if any, have provided responses to date?

Dr Studdert: We're still in an iterative process where we're looking to—
Senator STEELE-JOHN: So are you saying that none of those four departments have fully responded to Health?

Dr Studdert: No, I think they've all provided some material, but we're still working with them to finalise that response and I would think that we also need to talk to the Department of Finance—

Ms Soper: Yes.

Dr Studdert: as that progresses as well. So that would be in conjunction with the conversations with the department—

Senator STEELE-JOHN: Have you begun those consultations with the Department of Finance?

Dr Studdert: There have been some conversations, yes.

Senator STEELE-JOHN: Could you expand on that a bit. Some conversations—

Dr Studdert: As the secretary said, that then starts to play into budget processes and they are an ongoing process which we don't discuss in detail in these forums.

Senator STEELE-JOHN: So you're telling me that you have begun conversations, but you cannot inform me as to where the conversations specifically are—a timeline for—do you expect a response from the Department of Finance within the next couple of weeks, the next couple of months—

Dr Studdert: I suspect there will be conversations with the Department of Finance over the next couple of weeks and maybe quite possibly the next few months because of the budget cycles that we have to work within.

Senator STEELE-JOHN: Minister, is it your understanding that the health minister wants to respond to this report before or as part of the budget process?

Senator Colbeck: The advice I have from the minister's office is that he would like to respond very soon. You can make of that as you like, but that's the advice I have from the minister's office.

Senator STEELE-JOHN: So 'very soon' is the best we can get?

Senator Colbeck: Well, it's better than 'not soon'.

Senator STEELE-JOHN: It's not a very high bar, though, is it.

Senator Colbeck: I'm trying to be helpful.

Senator STEELE-JOHN: Not really.

Senator Colbeck: Well, actually, I would have thought—

Senator STEELE-JOHN: Not really.

Senator Colbeck: that was a reasonable response. I understand that you're looking for something more specific. I'm not in a position to give you that.

Senator STEELE-JOHN: I'm looking for nothing, Minister. Survivors are looking for something more specific.

Senator Colbeck: I acknowledge that and I think that's reasonable. My conversation with the minister's office was that he is looking to respond very soon. And, as you've heard, there
are a range of conversations that are afoot across government and processes that have to be undertaken, but the minister's office wouldn't have told me 'very soon' if they didn't mean that.

**Senator STEELE-JOHN:** Dr Studdert, you mentioned Finance there in the question of financial compensation. Is it therefore correct to say—

**Ms Beauchamp:** Sorry, Senator, I don't think Dr Studdert spoke about compensation. I think she spoke about financial arrangements. The financial arrangements and the recommendations include, amongst other things, additional access to health services and special arrangements around NDIS, which do involve financial considerations.

**Senator STEELE-JOHN:** One of the key recommendations of the Senate inquiry report, as you would well know, is financial compensation to survivors. Is that a recommendation that is being explored by Health or any other department as part of the response of government?

**Ms Beauchamp:** That's something that's being looked at and there is certainly nothing that's been put to government around it at this stage.

**Senator STEELE-JOHN:** But are there any direct conversations that have happened between—

**Ms Beauchamp:** I don't think I could go into any direct conversations, because, as I said, some of these—this is a decision for government and we're working with relevant agencies on coming up with advice to give to government.

**Senator STEELE-JOHN:** Do you intend to give advice to government in relation to the recommendations that speak to a redress scheme?

**Ms Beauchamp:** We will give advice to government on all the recommendations as part of a complete proposed response.

**Senator STEELE-JOHN:** Thank you.

**Senator HUGHES:** Could you maybe just update us on what payments have been received to date by survivors?

**Dr Studdert:** We can give you a little bit of information, but because it's not something that the government has been directly involved in, we don't have—we've never assumed that we have a full picture. There is some information that some of the survivors have shared with us and some we know from some of the reports and analyses that have been done over the years and the Senate inquiry. But I wouldn't want to purport that we have full picture or that we know and could advise on the full picture.

**Ms Soper:** I'm happy to give you what we have. It's worth pointing out that the Australian government does, of course, provide the Disability Support Pension for both singles and couples, so that has been provided to some survivors. Distillers and Diageo have made a number of payments throughout the period of time. In the 1970s there was a settlement with Distillers and a payment to parents of $48,407.69 per survivor. There was also a trust fund set up in that same period of time for $506,324.89 per survivor. In 2010 there was a separate settlement with Diageo and the average of that was $64,285 per annum. There was $1.1 million per beneficiary in total and that was scaled based on the severity of their injuries. Then in 2013 there was a separate settlement with Diageo of an average of $891,178.95 per survivor. We are not aware of the distribution arrangements of that.
Senator HUGHES: This isn't a new issue. Are you aware of any thalidomide survivors approaching any previous governments with regard to compensation payments or is this the first time it's ever come to government?

Dr Studdert: I don't think we are aware of an approach of the kind that has been made in the last few years. I think to some extent that has been—certainly we are quite mindful of the state of life that the survivors are getting to, where they are absolutely feeling the effects of a life lived with disability. From my understanding in conversations with some of the survivors and through the consultations that my team have done and certainly through what we heard from the inquiry, we understand why that effort has been made at this time. I'm not—I can't recall any other previous engagements such as we've seen in the last couple of years.

Ms Soper: No, not that we could find.

Senator HUGHES: thank you.

Senator STEELE-JOHN: I must pull you up there. You referenced survivors living with impacts of a life lived with disability. As somebody who lives a life impacted with disability, I must draw your attention to the distinction between living with cerebral palsy and living with something that was created as the result of a systemic regulatory failure—the most significant in this country's history. They are very different things—

Senator HUGHES: I don't—thalidomide wasn't under government control at the time it was marketed, was it?

Senator STEELE-JOHN: Senator Hughes, it absolutely was. Read the report. My distinction that I'm drawing your attention to, however, is that it would actually be considered rather offensive to equate a disabled person such as myself with a thalidomide survivor living with the effects of a regulatory failure—a man-made and imposed disability.

Dr Studdert: I absolutely apologise. I absolutely meant no offence. I was just recalling, as I have heard from the survivors I've talked to, their descriptions to me—

Senator STEELE-JOHN: They are dying.

Dr Studdert: Yes, exactly, and they have—

Senator STEELE-JOHN: They are dying, hence the urgency in my line of questioning.

Dr Studdert: Yes, I absolutely understand that and I apologise for any offence.

Senator O'NEILL: 'Very soon' can mean a whole lot of different things to different people. What sort of period of time do you mean when you say 'very soon', Senator Colbeck?

Senator Colbeck: It's not what I mean—it's the advice that I've received from the minister's office. I give it to you in the terms that it was provided to me. I would regard 'very soon' as the not-too-distant future.

Senator STEELE-JOHN: This is not a laughing matter.

Senator Colbeck: I'm not the one laughing, Senator. It is Senator O'Neill who is laughing at the response—

Senator O'NEILL: Yes, I'm laughing at your response—

Senator Colbeck: I'm trying to provide you—

Senator O'NEILL: because of the pressure—
Senator Colbeck: I'm not in a position to be able to—

Senator O'NEILL: that needs to be applied to government to get it to give a timely response.

Senator Colbeck: Senator O'Neil, stop talking over me as you've done all day.

CHAIR: Senator, please let the minister respond.

Senator O'NEILL: No, I haven't, but I do want—

CHAIR: Please let the minister respond to the question.

Senator Colbeck: I have given you a response that I've received from the minister's office. It's not given in any other way than within the intent that was intended, except to say 'very soon'. I would expect the minister, obviously, having met with some of the people who have had to manage their lives with the effects of thalidomide, understands that very well. I took it in the terms that he was—the intention of the minister was to deal with it very soon. That doesn't to me mean a long time—it means very soon. I'm not trying to—I think it's unfortunate that Senator O'Neill would try to put some type of interpretation on it. I cannot give you a specific date, as much I might like to—

Senator O'NEILL: Before you verbal, I'm the one who's asked you the questions, Senator Colbeck.

Senator Colbeck: Senator O'Neil, I've given you and Senator Steele-John a response that's been given to me by the minister's office. I think he's given it to me and to the committee with good intent and so I don't try to interpret it in any other way. He said to me and his office has said to me that he wants to respond to this report very soon. There's work being undertaken by the department as the lead agency with other agencies. So any sense to interpret this in any other than a response in good intent I refute. It's given in good intent and it's clear to me that the minister would like to respond to this very soon. I'm not trying—and I don't try to interpret it in any other way. As much as the committee or any particular senator might like a specific response, there are processes that we are dealing with and I'm sure the minister understands the urgency of the issues being brought to him via the committee.

Senator O'NEILL: With respect, Senator Colbeck, given that the report landed in March and here we are approaching November, I don't think it's unrealistic for the survivors of thalidomide and their families who care a great deal about your response to this report and who are waiting every day to ask—

Senator STEELE-JOHN: And watching now, I would think.

Senator O'NEILL: And wondering what's going on.

Senator Colbeck: Senators, you can characterise this any way you like.

Senator O'NEILL: Would you give them a commitment to deliver before Christmas?

Senator Colbeck: I am being quite genuine in my response—

Senator O'NEILL: I appreciate that—my question is—

Senator Colbeck: And you can verbal me all you like, Senator O'Neill, but my response has been quite genuine. The minister and the minister's office have told me that they'd like to deal with this very soon.

Senator O'NEILL: will there be a response to this community—
Senator Colbeck: That response has been given to me I think in good intent.

Senator O'NEILL: before Christmas.

CHAIR: Senator O'Neill, the minister has answered the question.

Senator O'NEILL: Will you commit to deliver before Christmas to the people who are waiting?

Senator Colbeck: If I could give you a date I would be more than happy to do so. But I am giving you the response that I've been given by the minister and his office as his representative here.

Senator STEELE-JOHN: They've waited 60 years.

Senator O'NEILL: Do you think it's unreasonable for thalidomide survivors to expect a response from the government before Christmas?

Senator Colbeck: I've said to you that the minister would like to respond to this very soon. I take him at his word.

Senator O'NEILL: Can I just indicate that Labor is certainly very much aware of this issue and very in line with the sentiments that Senator Steele-John has articulated here this afternoon. This is a matter that needs resolution and I think it should be given the highest priority in terms of response.

Senator McMAHON: My question relates to hospital funding arrangements. Could you please detail what are the arrangements that provide Commonwealth funding to hospitals in the Northern Territory?

Ms Edwards: Hospitals are primarily the responsibility of the government of the Northern Territory. They are the operator of the system and they make decisions about what procedures should or shouldn't happen in those hospitals, employ the doctors and all that sort of stuff. However, in accordance with an intergovernmental agreement, the government provides contribution to the cost of running public hospitals and that is managed in accordance with a complex funding formula which effectively is calculated by some independent bodies which are in existence—the Independent Hospital Pricing Authority and the administrator of the hospital funding body. It works by the states and territories providing data as to the activity that occurs in their hospitals. At the beginning of the year they provide an estimate—'we expect to provide this amount of activity'. The Independent Hospital Pricing Authority costs what is called the efficient price—how can you efficiently do a hip replacement or any other sort of procedure that happens in the hospital—and provides a price. Then we make payments through the funding administrator and they get allocated to local hospital networks. Then, at the end of the year, there is a reconciliation of how much activity did happen in the hospital in accordance with the formula and then there is a finalisation of the year. So that's the initial summary. Of course, in relation to private hospitals, the arrangements are different. But often MBS payments can be made in relation to services provided in those hospitals which are made by the Commonwealth. But the public hospitals is I think what you are mainly aiming at here.

Senator McMAHON: Do you know how much funding the NT government receives from the Commonwealth for NT hospitals?

Ms Edwards: Yes, I do. My colleague might have the numbers in front of her.
Ms Field: They are all available around the estimates in budget paper No 3, but I'm happy to read those out to you. Starting from 2018-19, we provide $290.8 million and then we are estimated in 2019-20 to provide $306.1 million; in 2020-21, $333 million; in 2021-22, $371.5 million; and in 2022-23, $404.3 million.

Senator McMAHON: Are there any requirements built into that funding for assured provision of certain services or is it completely up to the government in the hospital what services they provide?

Ms Edwards: We draw your attention to the intergovernmental agreement, which you can find on the Commonwealth state relations website. It's a very long document. But, in summary, there is a requirement that public patients receive public care free of charge, so that's something that is provided. There are some provisions in relation to safety and quality. So, for example, the Commonwealth will not provide funding in relation to activity where a particularly serious mistake might have happened and it provides a reduced level of funding if there is a hospital-acquired complication of some sort, noting that that money is retained for education and quality-driving purposes. But, in relation to what facilities are provided, in a public hospital, say, in a rural area of Victoria, the state might decide, 'We can't provide this sort of complex operation', so the person would have to be transported to Melbourne. So those decisions are fundamentally matters for the state or territory government.

Senator McMAHON: So there is no requirement to provide minimum basic services at any particular hospital?

Ms Edwards: No—there is an expectation that states and territories provide services for all the people who live there in a proper way, but they are the operators of the system. Probably if a hospital in a very populous place decided not to provide a very important service, we might certainly talk to the states and territories about that. But they are the runners of the hospitals and they make the decisions about what is managed where. That's why we have people airlifted to major hospitals in Sydney, for example, if there's something very rare or important.

Senator McMAHON: Would it concern you to know that the Katherine hospital in my hometown, which is a large, 60-bed regional hospital in a remote location serving 19,000 permanent population in the region, is no longer providing emergency minor surgical services to patients, forcing them to wait for days on end or drive 300 kilometres?

Ms Edwards: It's certainly information which we would be interested in receiving. We certainly might look into it. I certainly wouldn't be qualified to make a decision about that. I don't know if the Chief Medical Officer wanted to make about a comment about where and how we provide services.

Prof. Murphy: I'm not directly involved with it, but I think in a hospital of that size you'd expect to provide emergency care in that location. I'm not aware of the details of what's happening there, but generally speaking in that level of service emergency care would be something that's required.

Senator McMAHON: Would you be prepared to take that on notice and look into it?

Ms Edwards: Always, yes.

Senator McMAHON: Thank you.
Senator McCARTHY: While we're on hospitals, what is the status of the National Health
Reform Agreement negotiations of the states and territories?
Ms Edwards: Discussions are continuing, Senator.
Senator McCARTHY: That obviously includes the Northern Territory?
Ms Edwards: Correct.
Senator McCARTHY: When was the last time that you had a discussion with the
Northern Territory?
Ms Edwards: We have discussions all the time bilaterally and so on. It was on the agenda
for the recent Australian Health Ministers Advisory Council, which I attended. It's on the
agenda for the COAG Health Council in early November.
Senator McCARTHY: Is it still the case that six jurisdictions have signed a heads of
agreement but none have signed the final agreement?
Ms Edwards: Yes.
Senator McCARTHY: The final deal was originally meant to signed by the end of 2018
and that was pushed back to the end of 2019. Are you on track to meet that deadline?
Ms Edwards: We are certainly still aiming for that.
Senator McCARTHY: What meetings are scheduled to progress or sign the agreement?
Ms Edwards: As I mentioned, it's to be discussed as a major item on 1 November in Perth
by the COAG Health Council.
Senator McCARTHY: The committee has previously discussed a dispute over the
reconciliation of 2016 to 2017 funding which complicated the negotiations. COAG discussed
this issue in December 2018 and asked health officials to report back by June 2019 on better
processes to avoid such disputes in the future. Did that happen?
Ms Edwards: The direction by COAG to consider various clauses in relation to the
reconciliation process was taken very seriously by officials. Officials from all jurisdictions,
including those that have not signed on to the heads of agreement, have discussed it in some
detail. Lots of ideas have been progressed and it's now being considered by ministers. I expect
it to be raised at the meeting of the COAG Health Council on 1 November.
Senator McCARTHY: Have all states and territories agreed to that?
Ms Edwards: It's an ongoing discussion.
Senator McCARTHY: Okay. The last time the committee discussed this issue, in
February, you told the committee that the 2017-18 reconciliation was in progress. So your
response just then is the status of that reconciliation?
Ms Edwards: That reconciliation is concluded.
Senator McCARTHY: Thank you.
Senator O'NEILL: Can I go to national action plans. It's a long time since I started with
this this morning. It could be a lot longer until 11 o'clock tonight. I want to ask questions
about the national action plans and what's the status. During the October 2018 estimates round
the department told the committee that the minister had commissioned 15 national action
plans. I don't propose to go through all of them. I'm sure you know which ones they were. At
that time the department told the committee that 14 of them would be completed by now—the end of 2019. Did that happen?

Ms Soper: There are 14 being done in the preventive health part of the department—11 of those are chronic condition action plans and three are population-based. There are children's, women's and men's. Of those, three are not yet complete.

Senator O'Neill: Which ones are not complete?

Ms Soper: Heart disease and stroke, kidney disease, and rare diseases. They are all due to be finished in late 2019—so this calendar year.

Senator O'Neill: So you expect them to be concluded by Christmas?

Ms Soper: Yes.

Senator O'Neill: Very soon, to use that phrase. Have all of those 14, including the three that are not completed, been launched publicly?

Dr Studdert: Yes, Senator, they have. I have launch dates for all of them in front of me.

Senator O'Neill: Could you provide that on notice?

Dr Studdert: We can certainly do that, yes.

Senator O'Neill: Could you now, at this point in time, give me the launch dates for the heart disease and stroke?

Dr Studdert: That's one of the ones my colleague just mentioned hasn't been finished yet.

Senator O'Neill: It hasn't been finished, but it has been launched?

Dr Studdert: No—so the launch dates—

Senator O'Neill: Okay. My question was: of the 14—have all of these 14 been launched publicly and the answer was yes.

Dr Studdert: My apologies. The 11 that have been finalised have been launched. The three that Ms Soper just mentioned to you have not been finalised and thus have not been launched.

Senator O'Neill: So 11 and three, last time I added up, was only 14.

Dr Studdert: Then there is a 15th one, which is on stillbirth. Our colleague Mr Cotterell is here if you want to talk about that one specifically.

Senator O'Neill: We will come to that in a minute. So 11 of the 14 have been launched publicly and the heart disease and stroke, kidney disease and rare diseases are yet to be launched.

Dr Studdert: Yes.

Senator O'Neill: When do you expect that to happen?

Dr Studdert: I think, as Ms Soper just said, late 2019—so in the next couple of months.

Senator O'Neill: The 15th plan you've just indicated was stillbirth, not rare diseases. Is that correct?

Dr Studdert: Yes.

Senator O'Neill: So rare diseases—the status of that plan is that it is already operationalised?
Dr Studdert: No, that's one of the ones that has yet to be finalised and launched.

Senator O'NEILL: Okay. We have a few different terms running here—finalised and launched?

Dr Studdert: We finalise it and then we work with the minister's office around details for the launch—the minister's office and the organisations involved, because importantly all of these plans have been done in close consultation with peak bodies that represent consumers and communities that are closely associated with these respective conditions.

Senator O'NEILL: So there are 14 or 15 there. How many plans or strategies has the minister commissioned since that last update, which is now a year old?

Dr Studdert: As you might be aware, since the election the minister has launched the Long Term National Health Plan and associated with that he has announced plans for the government and the department so charged to develop a number of long-term health strategies in preventive health, health primary care, mental health and health workforce. Not all of them sit in my domain, so I don't want to misspeak for my colleague. That's where we are now looking to develop some long-term planning in close consultation with a very wide array of stakeholders. In many cases we will be looking to these specific disease strategic action plans, what we've learned through the process of developing those and the relationships we've built with a very wide array of stakeholder groups, including consumers and patients in many cases, and how we can bring some parts of those together into these longer-term views for investment in the health system.

Senator O'NEILL: So the longer-term one you cut out as something quite different from the actual discrete preventative health, for example—arthritis, childhood—

Dr Studdert: Yes.

Senator O'NEILL: It's quite different from those ones.

Dr Studdert: Yes, it's different, but we will not do them ignorant or without sight of these, because a lot of work has been invested in these, including in the case of the one that I'm closest to working on in terms of preventive health. All of these action plans have elements of them which are around prevention, so we are very minded to build on the work that's been done for these and the investments that have been made in some cases to ensure that we are not wasting that effort and we are continuing to mobilise our resources and efforts.

Senator O'NEILL: Let me just get to the rest of them. How many—my question was how many plans or strategies has the minister commissioned. So you've spoken to the Long Term National Health Plan, which has a subset of four elements.

Dr Studdert: The minister launched the Long Term National Health Plan at the Press Club—

Senator O'NEILL: Yes—what else?

Dr Studdert: and then he has commissioned us in the department—in various parts of the department. My colleague Mr Cotterell is working on the long-term primary health plan. I'm leading work on the long-term preventive health plan and other colleagues are working on mental health—you talked about that earlier this afternoon—and health workforce.

Senator O'NEILL: If I ask you about the National Preventative Health Strategy, is that the one that you are referring to that's embedded in that?
Dr Studdert: Yes.

Senator O'NEILL: And the 10-year Primary Health Care Plan—that's a second one that you're referring to within the Long Term National Health Plan?

Dr Studdert: Yes.

Senator O'NEILL: Okay. And additional to the prevention piece?

Dr Studdert: Prevention is the one—preventive health prevention—

Senator O'NEILL: Okay—national preventative health. What about the health workforce?

Dr Studdert: That's another part of our department.

Senator O'NEILL: And mental health as well?

Dr Studdert: Yes.

Senator O'NEILL: What other national plans or strategies are you aware of that the minister has also launched since you did your 15 last year?

Dr Studdert: I can't recall any on the spot here, but I'd be happy to take that on notice to be sure I've given you—

Ms Beauchamp: All the priorities are well set out in the Long Term National Health Plan in terms of all the action items and implementation priorities under that, which is available on our website and was launched in the last couple of months.

Senator O'NEILL: I guess my concern is that there are so many discrete bits that it's even difficult for the department to keep track of how many there are.

Dr Studdert: No, I wouldn't want to give you that impression.

Senator O'NEILL: How about the National Action Plan for Blood Cancers?

Dr Studdert: That's not in this outcome, in 2.4, but I'm sure there is someone that could come and talk to you about that.

Senator O'NEILL: But that's another national plan. I'm asking about the national plans. Is that a national plan or not a national plan?

Dr Studdert: I'd have to get the relevant officer to talk to you about that.

Senator O'NEILL: As I understand it, it was announced in September 2019 as a national plan for blood cancers.

Dr Studdert: Yes, I correct the record. My colleague Ms Creelman can talk to you about that one.

Senator O'NEILL: So there's another national plan?

Ms Beauchamp: Yes.

Senator O'NEILL: And what about the National Plan for Paediatric Palliative Care? There's another national plan.

Dr Studdert: Yes. Certainly, if you'd like us to take it on notice, we could get you a complete list of the plans. As you appreciate—

Senator O'NEILL: What about the National Obesity Strategy?
Dr Studdert: That's a strategy that's been developed through AHMAC and will go to the COAG Health Council, so that's working with all the jurisdictions.

Senator O'NEILL: You have to admit, though, there are an awful lot of separate national plans that have been announced?

Dr Studdert: Well, there are a lot of separate conditions and areas that this portfolio deals with.

Senator O'NEILL: Exactly. But they also require a high level of coordination and service provision.

Dr Studdert: Yes, and that's why in most of the cases, if not all—I will just check quickly—a lot of the work has been done by the organisations that represent the consumers and researchers and clinicians that work in those specific conditions. So we're certainly not setting out to be the experts on each of these. We're just providing the resources and the coordination that is necessary to bring those groups together and to involve them, because much of the work that needs to be done when those plans are finalised is not work the department can do or government can do; it is work that goes to a range of parties that work in those areas.

Senator O'NEILL: So, if we add them all up with the 14 from last year plus the four that are embedded in the Long Term National Health Plan, plus these additional ones, it's an ever-growing list. How many more do you expect the minister is going to announce before the end of the year or early in the new year?

Dr Studdert: I couldn't say. I think, as we said, there are a very large number of conditions and priorities that the minister set out in the long-term plan that, over time, we will put our attention to and support the sector to develop plans in. But I would certainly be happy to get you—

Senator O'NEILL: There are so many health conditions. Do you expect there to be a hundred? There are many more than a hundred conditions, so—

Dr Studdert: It's not something we've turned our minds to mapping out at this stage.

Senator O'NEILL: Okay. If I could ask you, on notice, so we get some clarity around this—because it appears that there's just a staggered and haphazard announcement of these over time—to give us a full update on each of the plans, including the 15 from last October, and the additional ones that I know of today that we've mentioned, and any others that may be hiding under other pieces of paper?

Dr Studdert: Could I just say it's not haphazard, in a sense. This is an opportunity for the department to work with key stakeholders and make sure everyone's on the same page in terms of the way forward, particularly around both these strategies, which are very long-term—over 10 years—and some of these action plans. So I think it's good to have a coordinating mechanism to make sure that we can bring key stakeholders together and, indeed, some of the states and territories so we are actually delivering a national plan.

Senator O'NEILL: If I look at this and count what we know, there are 23 plans—15 we knew about last year, five you've just told us about, three that I've had to remind you about. I would like a clear lay of the land—

Dr Studdert: Certainly.
Senator O'NEILL: because it's becoming a rather complex array of national plans, which must become quite difficult for coordination. When was it commissioned? What is the cost that is expected and the funding allocated, and is there any difference between those two things? What status is it—is it under development, is it completed, is it launched, is it not launched? Any government announcements in relation to the plan, and which specific recommendations from the plan do they relate to? What should we expect yet to be done? How will the remainder of the plan be considered and implemented?

Dr Studdert: Yes, we're very happy to do that for you, Senator.

Ms Beauchamp: It's not so simplistic, either. When you look at something like pain management, that involves a number of areas which we've already touched on today, around palliative care management and around codeine, and some of the work that has been happening in that space. I think there have been a number of initiatives that have come out of these action plans that have been pursued and are being implemented.

Senator O'NEILL: Thank you very much, Ms Beauchamp. Is there a mechanism in place to coordinate these 23 plans? For example, how will the National Preventative Health Strategy interact with the National Obesity Strategy?

Dr Studdert: I'm happy to talk to that, Senator. As I mentioned, the National Obesity Strategy is being developed through the AHMAC process, the Australian Health Ministers' Advisory Council. The government of Queensland is leading on that, and we are working closely with them, as are other jurisdictions. We've just started work on the National Preventative Health Strategy. I chaired a workshop of the expert steering committee just last month. We acknowledged up-front that we needed to work closely and have a line of sight to the development of the National Obesity Strategy, because that will be one part of the National Preventative Health Strategy. We will ensure that there is no—well, there may well be overlap, but that's a good thing in terms of reinforcing some of the key opportunities to coordinate national action, including with our state and territory colleagues. But we are most mindful that we don't double-up on efforts where there has already been extensive consultation and thinking around some of the evidence and ways forward. So we will be working very closely with those involved with developing the National Obesity Strategy, and that work will fold into and be a part of the development of the National Preventative Health Strategy.

Senator O'NEILL: I have the same sort of questions for other elements of the National Preventative Health Strategy. Clearly there will be some intersection with heart disease and stroke—

Dr Studdert: Absolutely.

Senator O'NEILL: and that hasn't even been launched yet.

Dr Studdert: But they are at a very advanced stage, obviously, if we're getting close to finalising.

Senator O'NEILL: The same with kidney disease and osteoporosis.

Dr Studdert: Yes, and as I mentioned earlier—
**Senator Colbeck:** Osteoporosis was launched last week. I am concerned that you are sort of suggesting that because there are so many there's some sort of trivial process. I can tell you, having been at the launch last week for the national osteoporosis—

**Senator O'NEILL:** I didn't say that, Senator Colbeck. I'm very aware, as a woman in particular, of the challenges of osteoporosis. My questions are about the coordination of all of this, and I think they're fair questions.

**Senator Colbeck:** At the launch last week, I can tell you, the response from those involved with that sector were appreciative of the launch and the fact that there were resources with it to actually start to progress research and action on the issues around that particular element of the broader process that we're going through. It's that specific action, I think, that talks to people specifically in those various areas. They are extremely appreciative of the fact that the plan was being developed and that the resources were being rolled out with the announcement. Not in an attempt to imply anything with respect to the conversation, but I think it demonstrates that these are very important for each of the different groups, particularly the groups that are dealing with those specific complaints. It means a lot to them that their particular issue, their particular medical condition, is actually being progressed in this way, as part of a broader way to progress dealing with the various health complaints that we deal with—and, in the context of osteoporosis, deal with in a preventative way.

**Senator O'NEILL:** Can you provide on notice a more detailed understanding of the mechanisms by which you operate an integration of new initiatives that are announced by the government with ones that are already underway, to make sure that there is no duplication and there is a maximised benefit from the investments around that particular issue. At this stage, I'm not confident that that has happened, so I'd like to understand that much more.

As I understand it, when the minister launches these plans, he usually announces what is a large sum of money to ordinary Australians but in terms of government expenditure a relatively modest amount of money to implement some parts of the plan—like the $4 million last week for osteoporosis. That's not going to resolve all the issues for osteoporosis in Australia; it's a part of a plan that gets announced and it gets some funding towards that particular part of the plan. My question goes to there being many other outstanding recommendations that are necessary to really deal with the issue—for example, osteoporosis in that plan—and the same being replicated in every other of the 23 areas. What happens to the outstanding recommendations that don't get any money allocated to them?

**Dr Studdert:** I think it's important to note that not all the recommendations in all the plans are for government. Often they go to ways of clinical practice, they go to clinical and research groups. And nor is the funding that is announced at the time of the launch the end of it. I think in the case of endometriosis the minister has made several announcements since that was launched—and I think that was one of the earliest ones to be launched—that go to addressing those recommendations. So it is an iterative process and it is not something that, even with all the money in the world, the government can answer in one single announcement at the time of the launch of the plan.

**Senator O'NEILL:** When you provide me with the answer on notice to the full update, could you indicate which parts of the plans are, at this point in time, in need of funding and as yet unfunded and any estimation of what those costs might be.
Dr Studdert: We'll certainly give you the information we have. I don't think in all cases all the recommendations have been fully costed, because not all of them fall to us to do that with. I would just reemphasise that the plans are not being developed entirely by government; they are being developed by the communities associated with those conditions for their own—

Senator O'NEILL: I'm not asking you to account for those parts which don't fall within your purview, but I am asking for an understanding of the bits that are the responsibility of government that are either already accepted and funded or yet to be funded. What's the formal process for the department or stakeholders to monitor the implementation of these plans?

Dr Studdert: I am quite sure that we will continue to have close dialogue with all the groups that have been involved in leading the development of these plans and that we will have regular updates from them on how they are progressing with the implementation in the respective communities.

Senator O'NEILL: Is there a clear set of outcomes to be achieved? Or is this just money that is allocated with a hope for the best?

Dr Studdert: For government funding allocated, absolutely we will follow that through the regular contract or grant administration arrangements. I misunderstood. You were talking about the plans as a whole, and that is something that would be done in conjunction with the group. But, in terms of any Commonwealth funding allocated, we would pursue monitoring and accountability for that through the regular processes.

Senator O'NEILL: There is a structure in place for formal evaluation and assessment of the value for the dollar that you are investing?

Dr Studdert: I suspect that that varies by plan.

Ms Soper: It does vary by plan. For example, for the endometriosis action plan, there is a steering committee that is made up of members of the community who have an interest or responsibility in that. They meet on a regular basis—a couple of times a year—and are running through what those outcomes are and where they are up to. They do differ by plan. It depends on the maturity of the plan. Some have only just been launched and some are much further along. Some of them have a range of different grant programs that will be going out, and of course we will monitor that as well.

Senator O'NEILL: Is there a risk that a lot of effort goes into developing these plans—trying to keep track of where everything is as they all pop up one after the other. A relatively small amount of money is committed at the commencement. When they are launched there is relief, hope and fanfare around that event, but potentially they just sit and gather dust with other outstanding recommendations never addressed. Is that a risk?

Dr Studdert: I can understand why you would ask that but I think we're absolutely assured that that won't happen because of the ownership that has been built in through the development of the plans by the groups involved. So in the case of arthritis, Arthritis Australia led on that and they will use that now as their roadmap for activity.

Senator O'NEILL: So the plans are really sticks for the community to beat the government up on if they don't deliver?

Dr Studdert: Quite possibly, yes!
Senator SIEWERT: You just touched on the issue around the National Preventive Health Strategy, and I heard you say that you had a meeting last night about it?

Dr Studdert: It was last month.

Senator SIEWERT: Sorry, I thought you said 'last March'!

Dr Studdert: No. I was looking at my estimates folder last night!

Senator SIEWERT: Oh right!

Ms Beauchamp: It was 26 September, yes.

Senator SIEWERT: Could you just let us know what the timetable is for its development, what's its planned date of delivery?

Dr Studdert: We had the first meeting of the expert steering committee on 26 September. We're now into a process of having a number of topic-specific workshops with a broad range of stakeholders. One of those was held last week—14 October—on cancer screening, and there are another four planned at this stage on nutrition and physical activity, prevention broadly, education and research, and tobacco. That reflects the priorities that the minister set out for the strategy, but he also spoke to the first meeting of the expert steering committee and said he was open to advice from that committee and through the course of the workshops as to what the breadth and scope of the strategy should be. He has asked us to work towards a mid-2020 delivery, but noted that we should do it well, because it is a 10-year strategy. He was open to feedback to the effect that if that wasn't achievable. We agreed as an expert steering committee that we would, in the first instance, work towards that delivery date but we will track that closely as we get into it, because, as you would appreciate, it's potentially a huge landscape to navigate, and one of the challenges we have is how to put together something that is manageable but, at the same time, comprehensive.

Senator SIEWERT: Do you have a budget for the preparation?

Ms Soper: We have procured the SAX Institute that is helping us write this strategy, and the value of that contract is $300,000.

Ms Beauchamp: They are facilitating the consultations as well as helping—

Ms Soper: Yes, they are.

Dr Studdert: I feel at this stage we have what we need but I also might say—to the boss—if we need more we will do what we need to do, because the minister has made it very clear that he is very intent on us doing this well.

Senator SIEWERT: You articulated the four key areas of the strategy. Do you envisage that the strategy will go as far as specific programs and policies to be implemented through the strategy?

Dr Studdert: First of all, can I just make sure I've been clear because I did read out the set of workshops. The four pillars that the minister put out as his priorities were cancer screening, immunisation, obesity and then prevention more broadly, incorporating tobacco amongst other things. I did mention an immunisation workshop in that list I just read out because there just quite recently has been quite detailed consultation with relevant stakeholders, so we're hoping to draw on that. I lost the train of your question, sorry.
Senator SIEWERT: My question was: will there be specific programs and policies around those areas in the strategy?

Dr Studdert: I think there could well be. We haven't got a specific target in terms of how it will be shaped. I think it's quite an interesting challenge for us to look at a 10-year horizon, how we set some directions and garner investment and step change that isn't guided by a small funding window. So I'm quite keen to ensure we do keep a bigger picture and a longer horizon in scope, especially at these early stages. Now, it might be, of course, as we get along the way that we identify some early deliverables or some early priorities, but I want to make sure we keep our horizon a bit longer so we take advantage of this opportunity to really set the direction for that 10-year period.

Ms Beauchamp: I hope we can actually leverage other parts of the health system, particularly when we speak about primary care, what we can do with MBS and prevention of chronic disease. So in terms of your question and the policy considerations, absolutely, those areas are a focus. But what can we do with other parts of the health system in preventing chronic disease?

Senator SIEWERT: Exactly, yes.

Dr Studdert: So a more systemic approach.

Senator SIEWERT: It will take up time for you to read out who is on the expert panel, but can you provide us—unless you can point me as to where I can find them—with the names of the people on the expert panel on notice?

Dr Studdert: I believe it's on our website and there is also a communique from our first meeting.

Senator SIEWERT: And that outlines who is on it?

Dr Studdert: Yes.

Senator SIEWERT: Okay, thank you. You haven't mentioned alcohol. Will alcohol be included? Or is that being dealt with under the separate strategy?

Dr Studdert: We do, of course, as discussed earlier, have a pretty close-to-being-finished national strategy, so I wouldn't want to be reenacting or reopening that but I think there will have to be linkages to that. We can't do prevention without looking at the impact of risk factors such as drug and alcohol abuse, and tobacco is included in that. We won't be relitigating the process of developing a national strategy specifically for alcohol but we'll certainly be looking to that as one of the risk factors that need to be accounted for.

Senator SIEWERT: So it'll cross-reference to that strategy?

Dr Studdert: Absolutely. The work that the previous national preventive health task force from quite a long time ago did—

Dr Studdert: That was 10 years ago.

Senator SIEWERT: Yes, in fact, when I held this portfolio! Are you going to be using any of that work that has previously been done?

Dr Studdert: I would say everything is on the table in terms of where the evidence is at, what we've learnt on policy and program implementation. The task force reports that were delivered 10 years ago were certainly very comprehensive at certainly very comprehensive at
the time. I think many of the experts we'll be consulting with will be updating us on what we've learnt in the 10 years since around best practice in implementation. But also I think we have to work with the system and the levers we have now. The secretary mentioned we'll be looking at those cross-linkages with other areas. I should mention that task force was quite specifically directed to look at tobacco, alcohol and obesity, and we have quite a bit more breadth in our remit at this stage.

Ms Beauchamp: I would hope that there has been a lot happening on the data and research and particularly the innovation and technology side that we can incorporate into this strategy.

Senator SIEWERT: Yes, you would hope so, in the last 10 years. I'm getting the eye! I have one final question in this section of my questions and that is: have you calculated how much you spend overall on preventive health measures in the portfolio area?

Dr Studdert: We do have fairly recent analysis from the AIHW around health expenditure and what proportion of that is attributed to public health.

Ms Soper: The AIHW, in its latest burden of disease report, says disease expenditure in Australia is estimated to be $117 billion of the health budget for federal, state and local governments, and approximately 50 per cent of that is spent on chronic conditions per annum. The AIHW estimates that Australia spends more than $2 billion on prevention each year or around $89 per person, and that estimation excludes other agencies and areas of the department outside of the public health category, so things like MBS and PBS.

Senator SIEWERT: Are not included?

Ms Soper: Are not included.

CHAIR: Senator Patrick, I understand you have some questions on outcome 2?

Senator PATRICK: In previous estimates, we've walked through issues in South Australia; although I won't pretend to say there are only issues in South Australia; there are difficulties with doctors all around the country in respect of regional areas. As a result of some of the discussions we had, the Senate then ordered the production of a document that was called the rural workforce agency health workforce needs assessment reporting template. I looked at that and of course it detailed a number of areas across South Australia where they still have great difficulty in filling positions. I now understand perhaps a lot more than what I did in the first instance there are many things that you are doing to try to get doctors to regional areas and I don't intend to criticise that. However, these problems have been longstanding. You are responsible for this particular area, I presume, and indeed you contract the Rural Doctors Workforce Agency with taxpayers' money to assist you in solving these problems but, if year after year after year we're not getting results, what do we need to change?

Prof. Murphy: I might start, and my colleague, Ms Holden, might follow on. I think probably the most pressing health workforce problem we have is getting the rural health workforce. As we discussed previously, in last year's budget, there are a range of strategies that we think will have a significant impact. Not all of them apply to South Australia but they're all across the country. There is a range of measures that are around end-to-end training of medical students, new programs for getting Australian-trained doctors experience in regional areas, getting the overseas-trained doctors across the country vocationally trained and
registered—we now have 354 of them doing specialist training—improved incentive programs for allied health and nursing practitioners, improved access to telehealth.

Importantly, in our general practice training program we're now turning out more than 1,000 new GPs a year, and half of those trainees are in rural and regional areas. It's really difficult to recruit them into those areas, but we have a very exciting future pipeline. Having said that, as I'm sure you will say, there are small country towns that are currently experiencing acute doctor shortages, and Minister Hunt, Minister Coulton and the department are very concerned about that. We're actively exploring what other models we can apply in some of those rural towns such as different models of employment. It seems that the younger GP is not prepared to go in and buy a practice and stay there for 60 years and retire at 75. We need to think about more flexible models whilst we bring on-stream all of those things that are coming. We clearly have enough GPs in Australia to meet our global needs; they're just in the wrong place, and we have to do everything we can to redistribute and make sure that new GPs are going to those areas.

Another important initiative we've done is put really substantial controls on overseas-trained doctors, so that they're not going into Melbourne and Sydney and Brisbane; they have to go where the rural health workforce agencies say they are needed. But on top of that, we're now providing proper support for them to train. We've got 6,000 overseas-trained doctors who don't currently have specialist qualifications. We have set up a program now, and 350 of them now are enrolled in formal training with financial support from the Commonwealth to get them trained and qualified. So it is a huge challenge.

The other thing I would say is that, more generally, there is an perception that primary care, general practice, is not as attractive as some other medical specialties. Minister Hunt is very committed to a primary care strategy and the first stage of that is the new voluntary enrolment scheme that will hopefully be developed to get extra funding into general practice. This is across the nation, but obviously that will help support rural practice.

I'm travelling with Ms Holden to western New South Wales in a few weeks to look at some of the innovative models. We might think about pooling state and Commonwealth resources. The state governments are spending millions of dollars on locums, which is probably wasted, whereas if we pooled our resources—Commonwealth and state—and had collaborative employment models in these very remote areas and remote areas, we could do better. We accept that it is a big challenge. Minister Coulton is absolutely on our back on this the whole time. The department's highest priority now is addressing those country towns that have current and predicted future doctor shortages. I don't know if Ms Holden wants to add anything else that we are doing.

Ms Holden: Professor Murphy has covered quite a lot. Two other parts to touch on would be the investment in the establishment of the rural generalist pathway, which we are in the process of progressing, and, in terms of those innovative models of care, looking at the opportunity for more integrated care, recognising it is not just the GP but also nurses, allied health, physios and a range of others.

Senator PATRICK: This organisation is very interested in performance obviously in the way that it delivers services and ultimately in the performance outcome. Could you indulge me with a response to a question on notice? Using South Australia as an example, could you highlight the country towns that don't have a doctor and, looking at the measures that you've
just described and the sausage machine—I'm loath to call it a sausage machine, because they're doctors—tell me how you estimate being able to fill those places? Obviously you can't map one of the sausages to a particular location, but you must have a sense, with all the money you're spending and all of these programs, that you will be getting doctors popping out at points in time. In essence I'm asking you for the KPIs that I might hold you to over the rest of this parliament.

Prof. Murphy: I think KPIs on a high level are probably very reasonable. One of the challenges in going town by town is that every town is different.

Senator PATRICK: I'm not suggesting you do that.

Prof. Murphy: There are often factors that have nothing to do with the Commonwealth or state medical programs there.

Senator PATRICK: It might be something that says that in January 2020 you expect to have filled three and then six months later a further two. We could see how that's tracking and see where people are leaving the system as well. There's lots of money being spent to achieve a particular objective.

Prof. Murphy: Sure.

Senator PATRICK: I'd like to be able to measure that.

Prof. Murphy: We've already got data that shows that over the last four years there has been a substantial increase in GP services and GP numbers in non-metropolitan areas. The modified Monash 6 and 7, the remote and very remote, is where there is still a deficiency, but all the other areas now have equivalent GP services per year to the metropolitan areas. Those smaller towns still have an increase. There's definitely an increase. We're reporting that there have been an extra 300 doctors in rural Australia in the last 12 months. It is a very challenging goal. I think it is right to be held to it, because we have to look at new and more innovative models to accelerate the pace. We know that—and this is central to the National Medical Workforce Strategy we are running—over the next 10 years we will have a lot of measures to redirect people from specialist practice that is oversupplied into general practice and to select the right rural origin people who will want to work and stay in the bush, but we don't have 10 years to fix the current problems we have. So at the moment our focus is on looking at what innovative models we can develop to help fill that gap until the longer term strategies come online.

Senator PATRICK: I'll give you scope to set your own KPIs for the hearing, but I'd be very grateful. If you're happy to restrict it to South Australia, if it makes it easier for you—

Senator O'NEILL: Oh, please, don't.

Senator PATRICK: What will happen is—

Senator O'NEILL: There's a community in New South Wales in Cobar, which I visited recently, that is facing this crisis right now. It's very concerning, because there is a mine nearby. There was a two-week period where the VMO was not provided by the state government. There are many places that are in crisis.

Senator PATRICK: I'm not suggesting this is about favouring one place over another. It's about looking and saying if we maybe have a sample of one area where these proposed
measures to fix the problems in New South Wales, Queensland and so forth are—I don't mind if you ask for New South Wales too.

Senator O'NEILL: If you want to restrict it, it's level 6 and 7 that seem to be the critical problem. I think that would be really helpful if we could get that data. That's not the whole country, but that's certainly where the big problem is.

Ms Holden: I'll place that one on notice.

Prof. Murphy: One other comment I would make is that the solution in these really small towns requires collaboration with state and territory governments, and we need that. That's one of the one of the things I'll be talking to health ministers about in a few weeks. I think we need pressure for every state and territory government to work closely with us—share the data, share the models and develop these collaborative shared solutions in these small towns—because the previous model of Commonwealth fee-for-service Medicare and state hospital services that don't come together is not a long-term solution.

Senator O'NEILL: They don't work in that context.

Ms Holden: Okay. Thank you.

Senator O'NEILL: Can I ask a couple of questions that follow-up directly from what Senator Patrick said with regard to GPs. I've had stakeholders advise that has been a 20 per cent fall in the number of applications for GP training positions since 2015. I'm also told that 63 first-year GP training places of 1,500 went unfilled in 2019. And stakeholders say that very poor conditions and pay compared to hospital based training programs are the main issues that are impacting that. We've got the sausage factory, but it's hitting a point of crisis.

CHAIR: Put those questions on notice, I think.

Prof. Murphy: Sure, very happy to.

Senator O'NEILL: If you could respond to that, that would be good, and a detail of where you're up to for the Rural Generalist Pathway—how many we've got going in New South Wales.

Prof. Murphy: We're very happy to respond. But we have a record number of general practice trainees, 5,300 at the moment, and we turned out more than a thousand new GPs this year. There has been a slight fall in the applicant numbers, but we had a huge expansion in applications over the last decade. We've doubled the number of funded training positions. We're happy to respond to that on notice. There are issues, as I said before, about attraction to GP training, and we're looking at some of those structural issues with the colleges of general practice at the moment.

Senator O'NEILL: And that was the next thing: what responsibility are the colleges undertaking in terms of the work for the distribution?

Prof. Murphy: Again, you put—I'm breaking into your dinnertime—

CHAIR: I'm very conscious of time and we are very running late.

Prof. Murphy: Just briefly, the colleges and the department are working really closely because the training is being transitioned to the colleges. The Commonwealth spends $300 million a year on GP training. We want to make sure that that training, when it transitions fully to the colleges, is the best possible training solution. Ms Holden is spending half her life working with the colleges on these issues at the moment. We're very cognisant of that.
Senator O'NEILL: My question is: what so they see as their moral responsibility? It's okay to manage their standards, but—

CHAIR: There are other questions I'm aware of that will be placed on notice, including from Senator McCarthy. It's obviously a popular area of discussion and we could have been here for many more hours.

Proceedings suspended from 18:38 to 19:30

CHAIR: We'll now move into outcome 3: sports and recreation.

Senator FARRELL: I welcome everybody involved in sports today. Ms Palmer, when the National Sports Plan was in its early stages of development, I asked a series of questions about whether the operations of the Australian Sports Commission and the Australian Institute of Sport would be considered as part of that process. If I recall the responses correctly, they effectively indicated that the AIS was being dealt with separately through the National Institute Network review, and that the Australian Sports Commission board had provided input into the National Sports Plan process. Is that a fair summary of earlier remarks and comments?

Ms Palmer: Yes. That is correct, except that the AIS high-performance elements are in the National Sport Plan.

Senator FARRELL: I'm just having a little bit of trouble hearing you.

Ms Palmer: The National Sport Plan does include high-performance elements, which are delivered by the Australian Institute of Sport.

Senator FARRELL: I understand. So it was felt at the time that a more comprehensive look at these two key sports entities was not required? When you were looking at the National Sport Plan, there was no investigation into the Sports Commission or the AIS.

Ms Palmer: No.

Ms Beauchamp: There was a commitment in the National Sports Plan to look at a review, particularly around legislation.

Senator FARRELL: I spotted a tweet recently by Tracey Holmes, who suggested that a review into the efficiency and effectiveness of all aspects of the Australian Sports Commission was under way. Is that correct?

Dr Studdert: Yes.

Senator FARRELL: That same tweet suggests that this review is being chaired by the former sports minister Rod Kemp, and that it takes a comprehensive look at the entire operation of both Sport Australia and the Australian Institute of Sport. Is that correct?

Dr Studdert: I might add other Commonwealth sport functions.

Senator FARRELL: Such as?

Dr Studdert: Including the Office for Sport in the Department of Health.

Senator FARRELL: Anything else?

Dr Studdert: Potentially there are other sport functions across the Commonwealth. There are small programs in the Department of Home Affairs and the National Indigenous Australians Agency. We are aware of a number of others, such as the Sports Diplomacy...
strategy that the Department of Foreign Affairs and Trade leads on. It's within scope for Mr Kemp to look at any and all of those.

Senator FARRELL: Does he make the choice as to whether he investigates?

Dr Studdert: He has quite a bit of latitude in his terms of reference.

Senator FARRELL: When did the review start?

Dr Studdert: It formally started last week.

Senator FARRELL: Last week. And when is it due to be completed?

Dr Studdert: The terms of reference have asked the lead reviewer and the associated consultants to complete it within ten weeks.

Senator FARRELL: And who commissioned the review?

Dr Studdert: The minister in conjunction with the board of Australian Sports Commission.

Senator FARRELL: Where would I find a copy of the terms of reference?

Senator Colbeck: We haven't published them. It's a functional efficiency review. It's a process of government that's not new. I think there have been something like 21 of them conducted since—

Ms Beauchamp: It's a normal part of government process, and I think Minister Cormann initiated these functional efficiency reviews some time ago, just to ensure we've got organisations, including departments, and indeed Commonwealth instrumentalities, that are fit for purpose now and for the future.

Senator FARRELL: Did you issue a press release about this, Minister?

Senator Colbeck: No, I didn't.

Senator FARRELL: Is there a problem with releasing the terms of reference?

Senator Colbeck: I hadn't contemplated that, Senator. As I said, it's a process of government. A number of agencies have them—in fact, when I was in the tourism portfolio, the Department of Foreign Affairs and Trade was having a functional efficiency review conducted, as were the War Memorial and a number of others. It's a process, from my perspective, that's prospective and will inform government around things such as the review of the act, which is part of the Sport 2030 plan.

Senator FARRELL: Is there a reason why the public can't have access to the terms of reference? Is there something secret about the inquiry?

Senator Colbeck: Not necessarily. It's a process of government in looking at the functional efficiency of its functions in undertaking those particular actions.

Senator FARRELL: Are you prepared to release the terms of reference?

Senator Colbeck: I'm happy to consider that. I'll take that on notice.

Senator FARRELL: Is it looking at the roles of Sport Australia and the AIS?

Senator Colbeck: It's looking at the functions of both government and Sport Australia and who can best and most efficiently carry out those functions—that's the fundamental purpose.

Senator FARRELL: Is it looking at the administration?
Senator Colbeck: Well, it's a function and efficiency review, so it's looking at the functions, the efficiency with which they're carried out and who is best served to undertake those functions.

Senator FARRELL: Does that include funding for the organisations?

Senator Colbeck: That may be an outcome. From talking to former minister Brendan Nelson, who's obviously CEO of the Australian War Memorial, they had a functional efficiency review conducted on them; I think it must have been about two years ago. That recommended additional funding for the War Memorial. So that may be an outcome of the functional efficiency review.

Senator FARRELL: So it may be that the recommendation is for more funding—

Senator Colbeck: It could be.

Senator FARRELL: or less funding?

Senator Colbeck: I'm tasking the review with looking at the functions and the efficiency with which they are carried out, so that I can look at the most effective way for the government to perform its functions in relation to sport.

Senator FARRELL: Is the review considering the cost of the work done by Sport Australia and the AIS?

Senator Colbeck: It'll consider the functions and the efficiency with which they're conducted and then—

Senator FARRELL: You've said that.

Senator Colbeck: make some recommendations in the context of—

Senator FARRELL: You've said that a few times, Minister.

Senator Colbeck: Well, because that's simply what it is, Senator Farrell. I'm not trying to be evasive in any way. It's a functional efficiency review.

Senator FARRELL: If you're not trying to be evasive, why didn't you tell the Australian community that you were undertaking this review and give us a bit of a clue about what the terms of reference were, then there would be no suggestion of evasiveness, or—

Senator Colbeck: I don't think that we've announced specifically any of the functional efficiency reviews that have been undertaken into departments, apart from the fact that we were doing them, whether it be DFAT, the War Memorial or any of the others. I wasn't aware, for example, until I spoke to Brendan Nelson, that there had been one into the War Memorial. It's a function of government to look at what it does, how efficiently it does it and how it most effectively will do it.

Senator FARRELL: Have you made any public statement about this inquiry?

Senator Colbeck: I haven't, no.

Senator FARRELL: So the community wouldn't be able to know about it—unless of course we came across that tweet by Ms Holmes.

Senator Colbeck: I understand there has been some other comment about it around the traps, but, again, as I've said, it's a process of government looking at how it best and most efficiently undertakes its functions, and I haven't seen it in any more light than that.
Senator FARRELL: What triggered the investigation? You could investigate a whole lot of government organisations. Why have you done this inquiry, and why have you done it now, and, more particularly—

Senator Colbeck: The Sport 2030 plan says that we will look at the act and what's written in the act. I think that this is a very reasonable precursor to that process, to understand what each element of government is doing and then how that might feed into any potential changes to the act. I have been presented with the Sport 2030 plan, which was brought down last year. I think a reasonable starting point is to understand who is doing what, how efficiently that is occurring and how we might better do it, and then we can look at whether there needs to be changes to the act. So it is an input to the process.

Senator FARRELL: An alternative proposition I would put to you, Minister, is that the time to have done this inquiry was when you were looking at the National Sports Plan. That was the sensible time to do it.

Senator Colbeck: If we had done that, we wouldn't have had a section in the plan that says that we will consider a review to the act. So I'd suggest that that's perhaps a bit counterintuitive. I'm reacting to the National Sports Plan, which says we will consider what's in the act.

Senator FARRELL: The proposition I'm putting to you is that the time to have done this inquiry was when you were coming out with the National Sports Plan. That was the sensible time to do it.

Senator Colbeck: I would differ, and I'm dealing with the circumstances that I'm presented with. I have a sports plan that says that we will consider a review of the act. What's my starting point for that? Looking at what we do, who does it and how efficiently it's done is, I think, a reasonable place to start.

Senator FARRELL: Who suggested to you that you should do it? Did you think of this yourself or did the department suggest that maybe now's the time to do it?

Senator Colbeck: I certainly had a conversation with the secretary. But, as I said, we've got a new sports plan which was launched last year. We've said that we're looking to implement elements of that. This is, from my perspective, part of that process.

Senator FARRELL: Secretary, why didn't you suggest it at the time that we were doing the National Sports Plan that we do this inquiry?

Ms Beauchamp: The inquiry is as a result of the Sports Plan. In terms of doing a legislative review, you really need to understand how we within the Commonwealth should be organising ourselves both from a legislative point of view but also a governance point of view to see if there are any legislative amendments that need to be made around the roles and responsibilities and whether some of the operational aspects that are contained in the legislation necessary. We're getting into the detail of the Commonwealth and how it organises itself in terms of sports governance.

Senator FARRELL: Yes, but, when you've spent all this time developing a sports plan—and you might recall that it got delayed and delayed and we waited and waited, and at every estimates we asked questions about when it was coming along—wouldn't the appropriate time to have done the sort of investigation that Mr Kemp is doing now been when you were doing
that whole process? Why couldn't you have done that inquiry as part of the inquiry into the National Sports Plan?

Ms Beauchamp: I guess it was a matter of priorities and making sure that other elements of the Sports Plan minister were implemented as well. So it's just a sequencing arrangement.

Senator FARRELL: But, while you're making a whole set of changes to sports in Australia, why wouldn't you have done your review at that time, as part of that process?

Ms Beauchamp: We didn't do our review at that time and we're doing it now, as flagged in the plan.

Senator Colbeck: Put simply: this is about delivery of the plan.

Senator FARRELL: Is it? Is that all we're talking about?

Senator Colbeck: That's my perspective of it. Coming into the portfolio, I'm presented with a plan and I have a look at the elements—

Senator FARRELL: So last year you came up with a plan and you're now doing an inquiry into the delivery of the plan. Is that what we are talking about?

Senator Colbeck: I'm looking at one element of the plan that suggests we will review the act. So my starting point is: what are the elements of a review of the act? And I thought this was a reasonable place to start.

Senator FARRELL: Apart from Mr Kemp, who else is involved in the review?

Ms Beauchamp: We've contracted through a selection process an organisation to assist Mr Kemp in the process.

Senator FARRELL: What organisation is that?

Ms Beauchamp: Ernst & Young.

Senator FARRELL: And that appointment was made by you, Secretary, or the minister?

Ms Beauchamp: The appointment of Ernst & Young?

Senator FARRELL: Yes.

Ms Beauchamp: It went through the proper procurement processes within the department and the decision was made by a panel that consisted of officers from the department and a Sports Commission board member.

Senator FARRELL: Which Sports Commission board member?

Ms Beauchamp: Mr Ireland.

Senator FARRELL: Was it an open tender?

Ms Beauchamp: Yes.

Senator FARRELL: How many people tendered for—

Dr Studdert: It wasn't open, Senator. It was off our panel for such services. We invited four firms to tender, based on their experience doing similar reviews in other Commonwealth entities. All four responded and the assessment process identified EY as the—

Senator FARRELL: Who were the other three tenderers?

Dr Studdert: Nous, KPMG and Deloitte.
**Senator FARRELL:** All right. This question might be premature given that the process only started last week, but how many consultations have been conducted with stakeholders as part of the review? Perhaps a better question might be: how many are intended to be consulted as part of the review?

**Dr Studdert:** The consultants and Mr Kemp met for the first time last week, and they were making a plan. I know that that was part of the conversation, as some of my team, some of the staff from ASC and I sat in on that meeting. The outcome of that was that they were going to prepare a consultation plan. I don't think there's been any—

**Senator FARRELL:** So we haven't got that far in the process?

**Dr Studdert:** No.

**Senator FARRELL:** Will you, or one of your officers, continue to be part of that process?

**Dr Studdert:** We will be available and called on as needed—the same with Ms Palmer and her team. But it's really up to Mr Kemp and the consultant team now to do what they want.

**Senator FARRELL:** At your meeting, did you work out how you might advise stakeholders that this inquiry is being undertaken and how they might make a submission or a contribution to it?

**Dr Studdert:** Not in specific detail. I think that's something they will work out. I'm sure, based on the experience EY has had—like other firms around have had—there's a way that they'll make contact with the various stakeholders and invite them to have a conversation or make a submission.

**Senator FARRELL:** I think the minister said you expect some results within 10 weeks.

**Dr Studdert:** That was what the minister and the board asked of Mr Kemp.

**Senator FARRELL:** And we think that time frame can be met?

**Dr Studdert:** It's certainly what they're working towards.

**Senator FARRELL:** When this report comes back, who will it come to?

**Dr Studdert:** The minister and the board.

**Senator FARRELL:** Minister, do you intend to make this report public?

**Senator Colbeck:** It's not been past practice with functional efficiency reviews, no.

**Senator FARRELL:** But what about this one; are you intending to make this one public?

**Senator Colbeck:** It wasn't my intention. It's a functional efficiency review and normally that goes into a process where we as government will determine a future direction. It's not my intention at this stage to release the report.

**Senator FARRELL:** So at this time we don't have the terms of reference, and we're not going to see the results. What do you hope to get out of this report? What's your aim here? What are you looking for?

**Senator Colbeck:** Well, as I said to you previously, I'm looking to consider potential changes to the act, to be able to consider the various functions that are conducted by
government agencies and the Australian Sports Commission and to look at who best and most efficiency can conduct those.

Senator FARRELL: Have you given Mr Kemp any direction as to what you'd like to see as the final—

Senator Colbeck: Mr Kemp and I have had a conversation. I've given him an open reign with respect to consultation. I've put no restriction on him at all. I've basically asked him to provide me with his recommendations as to what's reflected by the terms of reference.

Senator FARRELL: I'd like to ask some questions about the community sports grants program. It's providing important support to many clubs and communities to improve sporting facilities, which is obviously a very good thing. But there have been concerns raised about how the funding was awarded under the program, and I think we're expecting a report from the ANAO on that next month. I wonder if you could tell me, perhaps Ms Palmer, how many applications did Sport Australia receive across the three rounds of the Community Sport Infrastructure grants program?

Ms Palmer: Just over 2,000.

Senator FARRELL: Of those 2,000 applications, how many did Sport Australia recommend for funding?

Ms Palmer: In round 1 there were 224 grants. In round 2 there were 232. In round 3 there were 228.

Senator FARRELL: I got some responses to questions I put on notice in April relating to the CSI grants program. Those questions were No. 371 and 416. Those responses suggested that Minister McKenzie rejected a total of 618 of the grants Sport Australia had recommended for approval. Is that an unusually high proportion of recommended grants for the minister to reject?

Ms Palmer: I'm not privy to that. This is our first experience in this type of grant program.

Senator FARRELL: But the figure is right: 618 were rejected by Minister McKenzie?

Ms Palmer: Yes.

Senator FARRELL: Are you able to provide us with the list with the same sorts of details as published by Sport Australia on the Sport Australia website for the successful grant recipients of all grants recommended for approval but which were rejected by Minister McKenzie?

Ms Palmer: Could you state that again, please, Senator?

Senator FARRELL: Okay. So we know the minister rejected 618—

Ms Palmer: Yes.

Senator FARRELL: Are you able to provide us with the names of those 618 rejected applications? On the Sport Australia website it shows you the grants that you awarded and the nature of the grant application—what it was going to do.

Senator Colbeck: Take that on notice.

Senator FARRELL: Take it on notice to provide me with that information.

Senator Colbeck: We'll take the question on notice.
Senator FARRELL: Is it possible to get a list of those 618, and the nature of the—

Ms Palmer: This is subject to an ANAO investigation so we'd need to take that question on notice.

Senator FARRELL: Okay. Have they asked for this information?

Ms Palmer: We have provided a range of information. We have made all of our material available to them.

Senator FARRELL: Yes. But this specific question I have asked—have they asked for that same set of information?

Ms Palmer: We have provided them with all of the information relevant to the grants program.

Senator FARRELL: Which includes the 618 rejected applications?

Ms Palmer: It includes all of the information related to the program.

Senator FARRELL: Right.

Senator PATRICK: I'm sorry, but I actually think the senator asked a very specific question about whether or not it included some information. You actually haven't answered that question and I'd like to know the answer to it.

Senator Colbeck: On the contrary, Senator Patrick; Ms Palmer has answered it.

Senator PATRICK: No. She said, 'all relevant information to the Auditor-General's inquiry'.

Senator Colbeck: No. She said, 'all relevant information to the program'.

Ms Palmer: All material related to the program was provided to the ANAO.

Senator PATRICK: So it's reasonable to presume that includes the exact information?

Ms Palmer: Yes.

Senator PATRICK: Thank you.

Senator Colbeck: All the information relating to the program is 'all the information relating to the program'.

Senator PATRICK: Thank you.

Senator FARRELL: I'm not that familiar with these sorts of audits but do they typically publish that sort of information in the Auditor's report? Mr McCann, are you shaking your head there?

Ms Beauchamp: Senator, I'm going to ask the officers to be careful, because the Auditor-General is very specific, particularly around draft reports and other information that might be shared between the entity being audited and the Auditor-General, because of confidentiality requirements. So I don't want to get into any detail about what—

Senator FARRELL: No. Well, I'm getting absolutely nothing from you.

Ms Beauchamp: has or hasn't been provided. I'm just reminding senators, and certainly the officers, that they're bound by confidentiality agreements as to what has or hasn't been provided to the Auditor-General.

Senator FARRELL: Yes. But he can sleep very soundly tonight, Secretary, because we're getting nothing. We're getting no information about these grants from—
Ms Beauchamp: I think we've said we'll take it on notice.

Senator Colbeck: We have said we'll take it on notice.

Senator FARRELL: Yes, that's right. But he can't think that somehow we've had some confidential information that he is investigating at the moment, because we've not received any at this hearing tonight.

Senator Colbeck: Correct.

Senator FARRELL: All we know is that you're going to give some consideration to whether or not you will or will not provide it. I was asking the question: is it typical, when these reports come out, that that sort of information is contained in the report?

Ms Beauchamp: I think it probably would vary from report to report.

Senator Colbeck: It would depend on the program that's being looked at.

CHAIR: I know you have more questions, Senator Farrell, so we will come back to you. Senator Patrick.

Senator PATRICK: I want to ask some questions in relation to Equestrian Australia, Ms Palmer. I presume you're aware there's an experienced equestrian rider that has been charged with a very serious sexual offence?

Ms Palmer: Yes. That is a legal matter that is with the courts.

Senator PATRICK: Sure. I'm not really going to go into that. What's the normal situation with sporting bodies when a member of a sporting club or professional organisation is charged with an offence serious enough to be indictable? Indeed, obviously there is a threshold that is crossed before someone like a DPP would commence proceedings. So what's the norm in the sporting world?

Ms Palmer: There isn't a 'normal' process. It's a function of the governance of the organisation, and the board is responsible for making decisions on behalf of their organisation. The board makes the decisions related to those things. Their constitution would guide them, but there would be also potentially a policy which would guide how to manage processes and procedures in a range of different matters, including this type of matter.

Senator PATRICK: Do you have any sort of influence or control over the governance of sporting agencies which receive Commonwealth funding?

Ms Palmer: Sporting bodies that receive government funding are required to meet the mandatory governance principles. There is a range of functions in the principles that they need to follow.

Senator PATRICK: Do any of them go to the sort of matter that I was talking about, in terms of requirements to deal with a serious charge being laid by—

Ms Palmer: Yes. They would have child safety policies, they would have member protection policies and they would have guidelines on how to deal with sexual abuse matters.

Senator PATRICK: In this particular instance have you been engaged in any conversation with Equestrian Australia or had any correspondence with Equestrian Australia in relation to this?
Ms Palmer: We've been working with Equestrian Australia, and in actual fact all national sport organisations in this country, around their safeguarding policies. Our work in that area was a precursor to the royal commission into institutional child sexual abuse.

Senator PATRICK: But, in relation to this particular charge—this particular person, I'm not going to go into details of—have you been engaged in any correspondence or conversations with Equestrian Australia?

Ms Palmer: Yes. We've been working with them on this.

Senator PATRICK: It's known that that member has now been suspended. I'll be very up-front in saying no-one should read anything into that. It is my understanding there are many sporting bodies that do that. But that appeared to occur after the international body, to which they are responsible in terms of governance as well, suspended him. Is that correct?

Ms Palmer: Yes. I understand that's correct.

Senator PATRICK: Okay. So, in your engagement with Equestrian Australia, did you discuss suspension at all?

Ms Palmer: Yes, we did.

Senator PATRICK: Okay. Did you suggest to them that they might go down that particular pathway?

Ms Palmer: It's not our role to recommend to the board of a separate legal entity; we have no jurisdiction over that. We actually worked with the CEO around the matter. The relationship between all entities within a sport in this country are very complex. They have different constitutions and rules at every level. I think this is a good sign of an international body working in partnership with a national body to guide decision-making. It will set a standard globally, I suspect, in equestrian.

Senator PATRICK: I actually also wrote to the chair in relation to this matter, encouraging perhaps a suspension. I just wonder whether or not the organisation has been proactive enough, in your view, noting you know all of the other sporting bodies.

Ms Palmer: I think it's a very complex matter. It's not my role to have a view on how they've managed that. I think it does support the introduction of Sport Integrity Australia and the role of a body like that to actually help sports to understand this really complex world.

Senator PATRICK: There have been a number of other issues related to Equestrian Australia—and we've talked about them in the past at these hearings—in relation to bullying and harassment. Indeed, there was a coronial inquest into the death of some equestrian riders. Minister, I'm aware of a letter that might have been sent to you by the parents. Are you aware of that letter?

Senator Colbeck: Yes. I received that—I think last week.

Senator PATRICK: That letter—and I won't go to the details of that either—also perhaps raised some concerns about their response to the coronial inquest. Have you looked at that at all?

Senator Colbeck: That was the intent of the letter, I suppose. I received the letter initially and then an attachment a couple of days later that was referred to in the letter. A couple of days later that attachment came through. I'm considering the issues that have been forwarded to me in the letter.
Senator PATRICK: Is there anything that you can do as the minister in relation to this? I appreciate it's a separate entity, independent of government.

Senator Colbeck: I think that's the point. Obviously we are all concerned that sports conduct themselves in a proper and ethical way and that they have policies in place, as Ms Palmer has indicated, to ensure that people within the sport—whatever sport it might be—are dealt with fairly and ethically. The fact that these concerns are being raised is of concern, but my direct capacity to intervene, I have to say, is quite limited, in the same way that Sport Australia's is.

Senator PATRICK: Is there any federal body that could inquire into some of the allegations, noting that a number of allegations have been directed at the organisation? I know there was a change of board at one stage, wasn't there, Ms Palmer?

Senator Colbeck: There have been some changes, I think, in senior management of the organisation.

Ms Palmer: I think it's important to note that the government is invested in providing so that Equestrian Australia can introduce more safety standards and initiatives that will increase the safety in the sport. I understand they are considering the findings of the inquiry now. I would expect that there would be further work done in that area.

Senator Colbeck: The National Sports Tribunal, which we are in the process of setting up in response to the Wood review of integrity in sport, is one mechanism that might be able to assist in this area, although it is a body that requires both parties to agree to participate in an arbitration process. There are other functions of government, which you would be well and truly aware of; but, on the capacity to directly intervene, the advice that Ms Palmer has talked about being given to the sporting organisations through Sport Australia, I think, is a valuable point to note, but direct intervention is difficult because they are legal entities in their own right.

Senator PATRICK: So, obviously, they're not beyond a Senate inquiry if the Senate so chose to examine that particular sport, or indeed a range of sports, in respect of governments.

Senator Colbeck: The Senate can make its own decisions and make decisions to inquire into almost anything it desires, as you'd have discovered and I've seen. So that is a matter for the Senate itself to make a decision on.

Senator PATRICK: Of course. I was just exploring what options government had available and indeed trying to get an understanding of the level of the concern because my office has been approached by a number of people.

Senator Colbeck: If you're interested in having a conversation around that sort of process, I'm open to having that conversation.

Senator PATRICK: I'm grateful for that offer, Minister; I might take it up. Thank you very much, Chair.

Senator SIEWERT: Can I ask ASADA some questions about thymosin.

Mr Sharpe: What was your specific question?

Senator SIEWERT: I wanted to follow up the story from last week that said that thymosin beta-4 was not banned in 2012 when the Essendon players were found to have used it.
**Senator Colbeck:** Can I make a declaration right now that I'm a member of the Essendon Football Club just so that it doesn't come back to haunt me later—a long-suffering member!

**Mr Sharpe:** Thanks, Senator. Not wanting to upset my minister of course, I'll give you an answer. Just going back to the Essendon matter, which again was raised and will probably continue to be raised over the foreseeable future, the investigation was named Cobia. It was unprecedented for sport in Australia. As it relates to the media, the media is actually inaccurate and we, ASADA, corrected the record at the time. So—

**Senator SIEWERT:** This was the media release you put out that same day?

**Mr Sharpe:** That's right: in response to that media. So the allegations in the media, or the assertion in the media, was that ASADA controls the prohibited list. It doesn't; it has nothing to do with it. That's controlled by the World Anti-Doping Agency under their code which has a prohibited list. Thymosin was listed in 2010 on that list. There were allegations in the media that ASADA had manipulated that. ASADA does not control that list in any way. It was listed in 2010 as a prohibited substance under the prohibited list.

**Senator SIEWERT:** Do you have a copy—or can you tell me where I can access a copy—of that listing with its date for 2010?

**Mr Sharpe:** Yes. I'll take it on notice as to where to find it. The current prohibited list is online on WADA's website as it stands today, and that is updated quite regularly.

**Senator SIEWERT:** Exactly. If the issue is around dates, which is what it seems to be evolving around, and you've got something that actually has the list from 2010—or from the date it was listed or a copy of the list at that time—that would address that issue.

**Mr Sharpe:** Yes, absolutely. We can make that available on notice. Again, I just will note that that media talked about ASADA putting it on our website in 2013. Again, thymosin is a substance that is not approved in Australia. It's also a substance not approved for human use. It's not possible again for every single substance that's used to be captured independently on the WADA prohibited list. That's why they have a general category of substances which thymosin was listed under. When it talks about that substance, you cannot possibly list every substance, again, particularly when it's referenced to something that's not even for use in humans at the time.

**Senator SIEWERT:** If it's not actually physically listed on the list—is that what I understand you're saying?

**Mr Sharpe:** There are a number of categories within the list that are very specific. When you have a product, like thymosin, that's not listed for human use, it and a number of others, potentially, will be captured under a general category of substances. In 2010 it was captured under the—

**Senator SIEWERT:** So I understand it correctly—

**Mr Sharpe:** Yes, it's very complicated.

**Senator SIEWERT:** There's a general list and it's listed under that.

**Mr Sharpe:** Yes, that's right.

**Senator SIEWERT:** The other categories are more specific about what you can and can't use it for. Is that correct?
Mr Sharpe: More specific to substances. But it was under the category that listed it as a growth factor affecting muscle, tendon or ligament vascularisation and regenerative capacity.

Senator SIEWERT: To be really clear, so I understand it, the general list is still prohibited?

Mr Sharpe: That's right, yes. Again, I'll go back. ASADA does not control that list in any way. It is a WADA list, and it was listed on that by WADA in 2010. It's not our role—the allegation of manipulation; we cannot manipulate that list. It is not our list.

Senator SIEWERT: If you could take on notice provision of that list, so that we can see it from 2010, it would be very useful.

Mr McDonald: There is one other thing I would like to add, in relation to that. The fact that thymosin beta-4 was registered as prohibited was subject to the CAS hearing and a variety of other hearings that took place in relation to the 34 Essendon players. It was specifically considered in that hearing so that the outcomes and the recording of that would also cover off on that particular issue.

Senator SIEWERT: What date was that, just so I'm clear on dates?

Mr McDonald: The hearing, in relation to the matter?

Senator SIEWERT: Yes.

Mr McDonald: I'd need to go back and check.

Senator SIEWERT: Is that the 2014 one?

Mr McDonald: The fact that the substance was prohibited at the time it was alleged that the Essendon players had taken it was subject to that CAS hearing.

Senator SIEWERT: If you could check the date on that—was it 2014?

Mr Sharpe: It would have been around that time, yes.

Senator SIEWERT: Can you expand it a little bit further, in terms of what you just said about having to—did you say it was talked about extensively there?

Mr Sharpe: It was certainly the subject of extensive evidence provided, in relation to that and that fact of where thymosin was listed, when it was listed, how it was listed under the category. It was all taken as part of the evidence within the CAS hearing.

Senator SIEWERT: To your knowledge, has WADA done any further work on thymosin?

Mr Sharpe: WADA is constantly reviewing the prohibited list and has prohibited substances to go on that list. Going back to the general category, they are continually looking at different chemicals and products that are out there, particularly substances that aren't for human use. It's a continual process with WADA.

Senator SIEWERT: Thank you for that; that was useful. But have they specifically done it for thymosin?

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

Senator SIEWERT: If you could, that would be appreciated. If there's been any further listing, could you provide the details of any further listing, and if it is against something, and what the nature is of any further listing that's been undertaken?
Mr Sharpe: Certainly.

Senator FARRELL: I had some questions about Australia, but I will put them on notice. I have this, in the same vein. It's been reported that a complaint has been made to Sport Australia relating to the behaviour of some members of the Australian under-23 football team, the Olyroos. Is that correct?

Ms Palmer: Yes, we did receive a complaint.

Senator FARRELL: What was the process of handling that complaint?

Ms Palmer: We passed that complaint straight on to the sport, to the FFA.

Senator FARRELL: I suppose, to some extent, this is related to the questions asked by Senator Patrick. What avenues do members of sporting organisations have to resolve issues that they feel have not been appropriately dealt with by their state or national sporting organisations?

Ms Palmer: They would deal with that type of matter through their member-protection policy. There are guidelines there around how they might deal with those matters.

Senator FARRELL: Is every sport required to have one of those?

Ms Palmer: They are, yes.

Senator FARRELL: If a national sporting organisation doesn't resolve a complaint or dispute, what options are currently available to the individuals who've made that complaint or dispute?

Ms Palmer: I'll have to take that on notice.

Senator FARRELL: Is it fair to say that if a complaint is made to an NSO and the complainant feels it is not resolved they sometimes will complain about the NSO to Sport Australia?

Ms Palmer: Yes, that's correct.

Senator FARRELL: What does Sport Australia currently do in that situation? What powers or authority does it have to deal with such an issue?

Ms Palmer: It depends on the matter. In this instance, we have no jurisdiction so we're required to pass it on, but we might provide some advice about how they might resolve a matter.

Senator FARRELL: In the future, could complaints like that be considered by the General Division of the National Sports Tribunal?

Ms Palmer: Yes. I suspect that these sorts of matters will be addressed in that way. I think the benefit of the National Sports Tribunal, and Sport Integrity Australia more broadly, is the work that's being done on the frameworks and tools, policies and guidelines that will actually reach the grassroots of sport and the elite. It's a very comprehensive process, which is going to be wonderful for sport.

Senator FARRELL: Ms Palmer, you put in a correction to your evidence at the last estimates.

Ms Palmer: Yes.

Senator FARRELL: To quote from your correction:
some projects from the pool of eligible applications that were preferred by the minister were approved by her.

Do you recall that correction?

Ms Palmer: Yes.

Senator FARRELL: Is it correct to say that that referred to projects that the minister chose to approve but, while they were eligible, had not been recommended by funding from Sport Australia?

Ms Palmer: As the delegate, the minister approved the grants and was able to make the final decisions about the grants.

Senator FARRELL: But these were not recommendations made by Sport Australia; they were made by the minister.

Ms Palmer: They may not have been.

Senator FARRELL: They may not have been. How many projects were there that were not recommended by Sport Australia for funding but were approved by the minister?

Ms Palmer: In round 1, 293 were rejected; in round 2, 141 were rejected; and in round 3, 184 were rejected.

Senator FARRELL: Thank you.

Senator Colbeck: I just want to clarify whether that's those that were rejected but approved, or just rejected by Sport Australia?

Ms Palmer: The minister as the delegate made the decisions about the grants.

Senator Colbeck: I'm still not clear on the answer. Perhaps I've misinterpreted the question.

Senator FARRELL: Would you like me to read it out again, minister?

Senator Colbeck: I would just like to clarify that for the committee.

Senator FARRELL: My question was this: how many projects were there that were not recommended by Sport Australia for funding but were approved by the minister anyway?

Senator Colbeck: Unless I'm misinterpreting, I think the answer was in relation to projects that were actually rejected. Is that correct?

Ms Palmer: That's right. Yes, it is.

Senator Colbeck: So it's an answer to a different question, as I thought it might be.

Ms Palmer: Can I take that on notice. I would like to make sure it's correct.

Senator FARRELL: Okay, no problem.

Senator LINES: I was trying to chase up some funding around swimming pools. Is this the department?

Dr Studdert: That sort of depends on which program. We have a few programs.

Senator LINES: It's the funding of a swimming pool in south Perth.

Dr Studdert: If you could give us the details we could take it on notice and work it out, because there are a number of programs across the government. The program that we've just been talking about in Sport Australia, there's some funding that the department administers.
Senator LINES: So you don't know whether it's you or not.

Dr Studdert: I wouldn't be able to tell you right here.

Senator Colbeck: If you give us some details, we can assist. There have been projects that were funded out of the Infrastructure portfolio that have been moved into this portfolio, so details of that will help us with an answer.

Ms Beauchamp: Is there a particular question that we could file with a question on notice?

Senator LINES: I just want the details around the funding.

Ms Beauchamp: Right.

Senator LINES: I can put it on notice.

Dr Studdert: I'd like to make a minor correction. Earlier I said to Senator Farrell that Mr Kemp and the consultants had met for the first time last week. I've lost a week in my mental calendar. It was on the 10 October. I just wanted to be clear about that.

Senator FARRELL: So they have actually made more progress than we had been led to believe?

Dr Studdert: I hope so!

Senator Colbeck: Given they've only got 10 weeks, let's hope so!

CHAIR: We now conclude outcome 3 and move into outcome 4.

[20:19]

CHAIR: We will now have some questions in outcome 4.

Senator SIEWERT: Can I ask about the new MBS items for eating disorders? These are starting in the very near future, which is good.

Ms Shakespeare: They are starting on 1 November.

Senator SIEWERT: Yes, which the end of next week. I've got a series of questions. One is about credentialling. It's my understanding that the process of credentialling is still being refined. Is that correct?

Ms Shakespeare: No, the credentialling process will be as existing under MBS for items. I might get my colleague to provide more detail, but it is settled for the new items starting on 1 November.

Senator SIEWERT: Thank you.

Mr Simpson: As Ms Shakespeare has said, it is settled for the 1 November changes; however, there were recommendations in the report of the eating disorders working group that credentialling should be considered in the future, but that wasn't seen as an impediment to getting these items operational now. So there may be consideration at a future date.

Senator SIEWERT: Right. Pardon my confusion. I think I was mixing up the working group and where it is at the moment.

Mr Simpson: The items are ready to come in, but there is certainly advice on the table that there may be future work to be done.

Senator SIEWERT: In that case, when is that likely to happen in terms of any new changes that might be made?
Mr Simpson: I couldn't give you advice on that today. We haven't done the planning for that at this point. We've been very focused on getting the items ready for 1 November.

Senator SIEWERT: Why weren't the working group recommendations or expectations done prior to this process?

Mr Simpson: The advice from the working group was the changes to credentialling weren't critical to getting the implementation of the items for 1 November.

Senator SIEWERT: Is the department concerned at all that providers with no experience in this particular population may be providing advanced psychotherapies for this particular group?

Mr Simpson: The new items have been through an extensive consultation process with the sector and they are subject to the existing arrangements, as Mr Shakespeare has said, under the Better Access items. Patients are expected to progress through courses of treatment under the expanded suite of items. They will be under a consultant psychiatrist or their regular GP, who will regularly consult after 10, 20, and 30 sessions. As they progress through their severity, whether they need different skill sets from different clinicians involved will be assessed by those clinicians as they progress through.

Senator SIEWERT: In that case, that's the way that the people with adequate experience and expertise will be providing those services once they're monitored? That's how you plan to keep track of that?

Mr Simpson: That'll be a decision for the clinicians who have been responsible for initiating the treatment plan in the first place. They will be the ones who do the assessment. There are a range of clinicians who can be brought the process at different points of a patient's course of treatment, depending on their needs. The schedule and structure have been designed in a way that will allow bespoke skill sets from across different clinical areas to come in according to a patient's needs.

Senator SIEWERT: Have the professions that are able to provide services under these new items been expanded?

Mr Simpson: I would have to double-check that for you. I think that is the existing professions under the Better Access items, but I would want to clarify that for you.

Senator SIEWERT: Those professions that are already in Better Access will still be able to provide services under these item numbers?

Mr Simpson: The items are being monitored—on the existing items.

Senator SIEWERT: You're probably aware that there are some concerns because of the specifics around eating disorders and this being a high-risk group. There are some concerns being expressed about others than those with clinical expertise in psychology being able to access these item numbers. Have you had that concern expressed to you?

Mr Simpson: We have been receiving that feedback in recent weeks.

Senator SIEWERT: I ask for the department's response to that.

Mr Simpson: As I said, they are being rolled out based on the Better Access, really. The clinicians are registered under the relevant legislation in terms of their scope of practice and, really, their clinical decisions, as I said earlier, will be monitored by other clinicians involved in the process. If they need different skills sets to be brought in, that facility is there. We think
those are probably clinical decisions that are best handled by the treating GP or treating consultant psychiatrist.

Senator SIEWERT: Just so I am clear in this: there will be those checks, but there will be a plan for a person who is accessing these item numbers that is prepared by either the treating psychologist or—

Mr Simpson: Psychiatrist.

Senator SIEWERT: I beg your pardon—psychiatrist. I thought you had have said that, but then I was checking myself. Or it is the GP. So you're saying any profession that's accessing these item numbers will be part of a plan?

Mr Simpson: It's part of a collaborative arrangement, effectively. A GP or a psychiatrist may refer off to a psychologist or OTs. Obviously, dietetics are an important part of this process, depending on patient requirements. And they do have complex needs, so they do potentially need a complex range, but they will come back through those gateways and be re-assessed.

Senator SIEWERT: So it's not as if I can get this item number and then go off to a dietician or whoever without it being part of my plan.

Mr Simpson: And the plan is initiated by the GP or the psychiatrist at the initial phase before it even gets to the psychologist or other professional.

Senator SIEWERT: Got it. You said there was going to be review at 10, 20 and 30. That's correct, isn't it?

Mr Simpson: Yes.

Senator SIEWERT: What's the process? These are new item numbers—and, again, I'm not being critical of that; I think it's really good that we are doing this—but are you going to look at the effectiveness of this new process at some stage down the track? Will you look at whether this particular approach is working?

Mr Simpson: I anticipate we'll be working with the sector. We've had a lot of feedback. To date, the sector has been highly involved in the implementation of these items and giving us advice on how the items should be structured, so I'm anticipating that we'll be continuing to work with those stakeholders and that we'll be getting their feedback.

Senator SIEWERT: What's the time line for that process?

Mr Simpson: We haven't put a time line in place, but as the items are implemented and we get data on their utilisation and feedback on their effectiveness—as you would be aware, hitting 40 sessions is not necessarily an indication of their effectiveness. If the sector tells us they're effective because they're getting ten or 20 and resolving the underlying problems or putting people on a more stable footing or maintenance plan then that might be a measure of effectiveness. We'll have to put measures in place, as well as item utilisation, but that will happen once we start to get some data through from the items and experience from the clinicians using them.

Senator SIEWERT: I know 40 sounds like a lot; but we're talking about very significant issues, so presumably you'll also be looking at that end as well?

Mr Simpson: It's 40 annually and it's on a rolling 12-month basis. Then there are the 20 dietetic sessions on top of that. Traditionally I think the items have been—I haven't got the
figures to hand, but there hasn't always been 'stickiness', I guess you'd say, in terms of people getting through all their sessions, so I think it allows people to have a real program and know that 40 sessions over a 12-month period is a lot from an organisational point of view for patients and doctors.

Senator SIEWERT: Can I go back to the credentialing and close up there? In terms of the credentialing side of things, you don't have a time frame for when you are looking at the working group's expectations?

Mr Simpson: No, not at this point.

Senator SIEWERT: Is it short or longer? I'm not trying to be difficult; I'm just trying to get an idea as to whether it is short, medium or long-term?

Mr Simpson: We'll have to have discussions with our colleagues in the health workforce who look after credentialing, so I wouldn't want to—

Senator SIEWERT: Maybe I'll be coming back in February.

Mr Simpson: Yes, I think in February we'll have more detail for you.

Senator HUGHES: I have a couple of quick questions. Could you give us a bit of a sense of how much the government is spending on these eating disorder programs, particularly MBS services?

Mr Weiss: This was a measure in the 2018-19 MYEFO, I think, and the estimated cost was $110 million over the forward estimates.

Senator HUGHES: How does that compare with previous investments into eating disorders in particular?

Ms Shakespeare: I think we'd need to take that on notice. I'm not sure that we've had any specific investments in eating disorders under the MBS, but there may have been other grant programs across the department in the past. We'd need to check.

Senator HUGHES: You don't know about anything specifically focused on eating disorders?

Ms Shakespeare: Certainly not in the Health Financing Group.

Senator HUGHES: If you could take that on notice, that would be great.

Senator SIEWERT: I just want to go back to the evaluation process. Will there be a process in place, besides the 10 and 20 process, to look at whether the treatments are effective, to make sure that the items are being used as anticipated—does that make sense?—and to make sure that this process isn't causing further harm?

Ms Shakespeare: We are looking at putting in place new arrangements. The task force itself, as a piece of work, is going right through every item on the MBS, but once that review of every item is completed we don't want to just pack up and leave. We need to introduce new arrangements going forward to make sure that all of the new items that we're introducing—because there are significant changes from the task force; I think we're looking at 800 a year for the next few years—have been effective. We want to have something similar to the utilisation reviews, which we've had over a number of years for medicines, and post-market reviews but to bring them into an MBS context. We don't know exactly when that will happen. We'll need to schedule utilisation reviews and ongoing reviews with our independent
experts to say, 'I think that you really need to look at these after this period of time.' I'd say that there wouldn't be any useful data for these new items for at least 12 months, and probably a bit longer, before we would be able to review them and see whether or not they've been effective.

Senator SIEWERT: Thank you.

Senator LINES: I want to talk about MRI. I want to have a chat about the invitation-to-apply process for the Medicare MRI licences. I think at a previous estimates you told the committee that you didn't provide the 53 recommendations to the minister but that instead you assessed all 493 applications and provided those to the minister and that he picked the top 53 from that list. Is that roughly right?

Ms Shakespeare: The department certainly provided an assessment of all 493 applications to the invitation-to-apply process. There wasn't a list of 53 ranked in order provided by the department.

Senator LINES: No, no, I wasn't suggesting that. I'm sorry if I gave you that impression.

Ms Shakespeare: The department did provide advice against each of the applications, but the decisions were decisions of government.

Senator LINES: So the minister picked the 53?

Mr Weiss: If I can clarify a little bit, 10 were announced prior to the conduct of the invitation to apply.

Senator LINES: So he did 43?

Mr Weiss: Yes.

Senator LINES: When you gave that assessment of the 493, how did you assess each application?

Ms Shakespeare: It's quite a detailed process, and I'm happy to take you through it. The invitation-to-apply documents were originally developed by the department. They were then approved by the minister. They were then released on, I think, 23 September last year. The ITA documentation was clear that there were some providers—

Senator LINES: ITA being 'invitation to apply'?

Ms Shakespeare: Invitation-to-apply documentation, I should say. For instance, providers with existing fully eligible machines were not eligible to apply for another unit, and the documents stated that preference would be given to applications for MRI units located in PHNs—Primary Health Networks—with high relative need to other PHNs, based on the number of fully eligible units per capita in each PHN, with the intention to more evenly distribute the number of fully eligible MRI units per capita across Australia.

Senator LINES: So where they met that criteria they were ranked, from closest match downwards?

Ms Shakespeare: They were just framing criteria. We then had a series of what we call 'mandatory criteria' that each application needed to meet in order to advance through the assessment process. The mandatory criteria included that the MRI units that were the subject of the application had to be capable of providing all MRI services listed in the relevant group of the Medicare diagnostic imaging services table, excluding breast or cardiac MRI, or
Senator LINES: So, a pretty thorough framing process of mandatory criteria.

Ms Shakespeare: Those who met those mandatory criteria were then assessed against what we call substantive criteria, and these had ranking scores for each criterion applied. The first substantive criterion was around practice details, which contributed to 34 per cent of the score. That related to where the MRI unit was located, its opening hours, accessibility for people with a disability, reporting times between when the imaging occurred and when the report went back to the requesting doctor, and whether the practice is willing to bulk-bill some or all patients.

The second substantive criterion, which contributed to 22 per cent of the ranked score, was patient catchment and access. That included looking at the estimated patient catchment area; other practices with MRI that already service that area that are within 30 kilometres of the identified location; the distance in kilometres to the nearest Medicare-eligible MRI service; socioeconomic status of the catchment area—SEIFA data; the number of requesting practitioners available; and other key medical services available.

The third substantive criterion was around the range of services provided, which contributed 16 per cent to the score—whether a range of MRI services were provided at the practice. We also considered here whether the practice was a public or a private hospital and, if a hospital, the number of beds and the hospital’s categorisation. The fourth criterion was the staffing profile, which contributed to 16 per cent of the score. That relates to the availability of radiologists onsite and supervision arrangements.

Senator LINES: When you say onsite, do you mean 24/7?

Ms Shakespeare: If it was a 24/7 practice and they had a radiologist onsite 24/7, that would rank higher. And the last criterion related to equipment details, which contributed to 12 per cent of the score. That looked at the age of the equipment, the magnet strength—whether it was 3 tesla or 1.5 tesla—as well as whether the unit was capable of catering for patients who require lower magnet strength. Those were all the criteria we considered. There was also information that was requested from state and territory governments that was considered, about their views on the need for MRI eligibility in particular areas. So, there was a very
rigorous assessment, and we went through all the 193 applications and did checks within the applications to make sure they were accurate. If somebody had ticked the box on the form that said that they were open 24 hours a day seven days a week but when we actually got into the application they spoke about being open Monday to Friday from nine to five, we marked those scores. There were several people involved in looking at each of the applications.

Senator LINES: And these are publicly available, aren't they?

Ms Shakespeare: No—

Senator LINES: I beg your pardon—the criteria.

Ms Beauchamp: The criteria are on our website, and there's a very comprehensive document there.

Senator LINES: Did any of the 53 licences—the 10 and then the 43—that were granted have a lower assessment score than applications that were rejected?

Ms Shakespeare: As I said, we didn't rank all of the applications in a linear order. We provided advice by PHN, given that that was the main criterion in the ITA that we were going to apply to ensure a more even distribution of MRI eligibility. So the advice we provided was on a PHN basis and within PHNs if there were particular facilities that met the criteria to a greater extent than other facilities.

Senator LINES: Across the PHNs, then, did any of the licences that were granted have a lower assessment score than applications that were rejected?

Ms Shakespeare: I don't think that we provided the scores in order. We provided advice on the PHN, and the department's advice was at a time when the funding had been announced at the beginning of the ITA process for, I think, a total of 21 additional MRI—sorry, 20. I think during the assessment process, because there were two streams—there were MRI upgrades as well as fully eligible new units—we managed to recommend 21 because of the—

Senator LINES: Yes. But back to what I was asking: across the PHNs, were any licences granted that had a lower assessment score than applications that were rejected but didn't succeed in getting an MRI?

Ms Shakespeare: Not to my knowledge, but I'd like to check back in detail through the list that we provided.

Senator LINES: Okay.

Senator Colbeck: I think it is worth noting that, from the information I have seen, patient access was improved across 85 per cent of PHNs.

Senator LINES: That's not what I'm asking, Minister.

Senator Colbeck: Well, I'm making the point.

Senator LINES: Sure.

Senator Colbeck: Over 27 of 31 PHNs, patient access was improved.

Senator LINES: It's late, and I really want to continue along the line of questioning that I've got. If you go back and look at what you've taken on notice now, if there were MRIs that had a lower assessment score than applications that were rejected, can you tell me which ones? We just want to know which ones.

Ms Shakespeare: So which of the successful MRIs?
Senator LINES: Yes. If they had a lower score than ones that were rejected, which ones were those?

Ms Shakespeare: We'll take that on notice.

Senator LINES: Do you know, or does anyone here know, whether any rejected applications were ranked more highly by the department than Sound Radiology in Parkside, South Australia, which did receive a licence?

Ms Shakespeare: I think we'll need to take that on notice too.

Senator LINES: You don't have anyone who can answer it tonight? Mr Weiss?

Mr Weiss: No, we don't.

Senator LINES: There's no-one here from all the officials in the room? You don't have that information.

Ms Shakespeare: Not with access to the micro detail of the 493 locations.

Senator LINES: I'm asking about a specific one, Sound Radiology in Parkside, South Australia.

Ms Shakespeare: We don't have the details of the 493 here, but we're happy to take that on notice.

Senator LINES: Including that question about Sound Radiology in Parkside?

Ms Shakespeare: Yes.

Senator LINES: Okay. If you're taking that on notice, look at the number that might have been rejected in terms of that licence. The other point that I want to know—and perhaps you can answer this—is; are you aware of whether or not the application for Sound Radiology met all mandatory criteria and the substantive criteria from your department, including opening hours and practice location?

Ms Shakespeare: It met all mandatory criteria. The substantive criteria were weighted.

Senator LINES: How can you answer that question and not my first question?

Ms Shakespeare: I know that there were none of the applications that were approved that did not meet mandatory criteria. That was a rigorous part of our assessment.

Senator LINES: All right. In relation to Sound Radiology in Parkside, are you able to get that information tonight?

Ms Shakespeare: Given that it's quite late, I think the people that worked on this are probably not at work anymore.

Senator LINES: Thinking back again about Sound Radiology, the other question that I've got is: what score did that application receive on the scale that you received earlier?

Ms Shakespeare: I'll need to take that on notice. We don't have the details of all of the scores for all of the applications here tonight.

Senator LINES: Okay. In relation to Sound Radiology, can you table all correspondence relating to the application?

Ms Shakespeare: I'm sure we can do that.
Senator LINES: But you need to take that on notice, or are you able to provide that tonight?

Ms Shakespeare: I'm sorry; I've just realised maybe we can't provide all of the application. There is some information that's been published around all of the successful MRI units, but the information that the department collects as part of the ITA process, from all of the applicants, is protected by section 130 of the Health Insurance Act, which prevents us from divulging or communicating to any person any information with respect to the affairs of another person acquired in the performance of our duties under the legislation. It's actually an offence.

Senator LINES: So you think it covers these applications?

Ms Shakespeare: Well, because these were applications for Medicare-eligible services, it's almost certainly going to apply to the applications.

Senator LINES: But you're not sure, if you said 'almost certainly'.

Ms Shakespeare: I'd need to check that with our department's lawyers.

Senator LINES: Sure, if you'd do that. I have similar questions about SKG in Mandurah, WA. Were any rejected applications ranked more highly by the department than that service in Mandurah, which received a licence?

Ms Shakespeare: I do know that that one was recommended by the department in the initial group of 20, 21. I don't think so, but, again, I'd like to check that.

Senator LINES: Okay. Again, if the answer to that is yes, how many other rejected applications were there? I'm assuming that the application for SKG in Mandurah met the mandatory criteria?

Ms Shakespeare: Yes, it did.

Senator LINES: Right, because you said they had to. What about the substantive criteria, the ranked criteria?

Ms Shakespeare: The department ranked that one highly in the initial tranche of 21 recommendations.

Senator LINES: And including its opening hours and practice location?

Ms Shakespeare: All of that would have been taken into account through that assessment process I mentioned earlier in the department forming the recommendation that that one should be granted an upgrade to an MRI licence.

Senator LINES: Can you tell us what score that application received on the scale you described earlier?

Ms Shakespeare: I don't have that detail here with me tonight. We can take that on notice.

Senator LINES: Likewise, if you can just check whether you can table all correspondence in relation to SKG in Mandurah.

Ms Shakespeare: Subject to that legal advice.

Senator LINES: Yes, absolutely, same criteria.

Senator GRiff: Would you be able to advise the total MBS costs for GP in-home visits specifically providing services to be considered to be for palliative care patients each year?
Ms Shakespeare: I'm not sure that we're going to be able to identify GP services provided for in-home visits for palliative care purposes. I'm not sure that there are any specific items. Many of the GP MBS rebates are paid for general services, which can be provided to people regardless of their condition. We'll certainly look into what we can provide to you about what's able to be identified as palliative care.

Senator Griff: If you could, I'd be interested to see what that is for the last three years. I note that items 3018, 3023 and 3028, which don't appear to be available to GPs, appear to provide specialist palliative medicine to a patient in their own home. Would that be correct?

Ms Shakespeare: I think we'd need to check on those specific items and get back to you.

Senator Griff: Okay. So there's no way at this stage that you can identify if a regular GP, apart from a specialist with those item numbers, is attending for palliative care purposes?

Ms Shakespeare: We have after-hours items, which I imagine could be provided by a GP who was visiting somebody for palliative care purposes, but because they're not—

Senator Griff: But that's a general after-hours item, urgent—

Ms Shakespeare: That's right.

Mr Weiss: Unless the item descriptor specified that it was a home visit for palliative care purposes, we wouldn't be able to identify. So, if it's just a general item, we don't know what the home visit was for—whether it was for palliative care or for some other form of care. That information just won't be available.

Senator Griff: Okay. I imagine this again will be on notice. MBS items 735, 739, 743, 747, 750 and 758 are described as being for patients who have a medical condition that either is likely to extend beyond six months or is terminal. Would that be the correct interpretation of those items? Again I know you'll want to take that on notice. These items provide for a GP to coordinate or participate in a multidisciplinary case conference in the community or a residential aged-care facility. I imagine you'll need to check that. How does the department distinguish between services provided for those who have conditions that extend beyond six months and those receiving end-of-life care in the community?

Ms Shakespeare: Would it be okay if we did take those questions on notice? We haven't got the details here with us at the moment.

Senator Griff: All right. The rest in that vein I'll put on notice, because I think that will make your life a lot easier. I have just another couple of questions. Most of mine will be in outcome 5, a little bit later. There have been reports about surgeons double-booking operations, if you like, where a surgeon books in a patient with one operation and overlaps the next. In this case a lead surgeon will perform the key element of surgery and then another surgeon, often a junior, will finish up the operation while the lead surgeon moves on to the next operation. Do you have any data on that, and is it something that concerns you or is it considered to be a nonissue?

Prof. Murphy: Quite often a surgeon will have an assistant surgeon with him or her, and the assistant surgeon has a special MBS fee, which is a reduction. Only one surgeon can claim the primary operating fee, and the assistant can claim an assistant's fee. It wouldn't be unreasonable if the surgeon and the assistant were in two theatres, the surgeon did the operation with the assistant, and the assistant were closing up the wound while the surgeon
was in the next theatre, because Medicare is only paying for one primary fee for most of the time both surgeons are with each patient. If there were a period of crossover where the assistant was closing up and the surgeon was starting in the next theatre, I don't think that would be seen by our provider compliance people to be a problem. It would be a problem if two people were charging the primary operating fee, but that's not possible under Medicare.

Senator GRIFF: Okay. The other questions I have in outcome 4 I'll put on notice in the interests of getting to outcome 5 quickly.

Senator SIEWERT: Could I go to the MBS review. How many recommendations have been made to government since the commencement of the review?

Mr Weiss: My memory of this is that there have been 332 recommendations made to government, to this point in time.

Senator SIEWERT: How many of those have now been dealt with by government?

Mr Weiss: Almost 300. The figure in my head is 297, but I'll—

Ms Shakespeare: Two hundred and ninety-seven recommendations is correct.

Senator SIEWERT: Have been dealt with by government?

Mr Weiss: Yes.

Ms Shakespeare: Accepted by government.

Senator SIEWERT: So 297 have been accepted?

Ms Shakespeare: And there are 35 recommendations under consideration.

Senator SIEWERT: You've anticipated my next question. None have been rejected? That's according to my maths.

Ms Shakespeare: We break down the accepted recommendations to recommendations accepted in full and recommendations accepted in a modified form.

Senator SIEWERT: How many have been accepted in full and how many in a modified form?

Ms Shakespeare: There have been 277 accepted in full and 20 accepted in a modified form.

Senator SIEWERT: How modified were they?

Ms Shakespeare: Probably a good example was the urgent after-hours items, where the government made changes to the after-hours items to retain different types of rebates for vocationally registered and non vocationally registered doctors providing urgent after-hours services, and a range of other policy changes to try to make sure that urgent after-hours items were actually being claimed for urgent services, whereas the task force had recommended that those urgent after-hours items should be limited to doctors who didn't usually work in the after-hours period. The intent of the recommendation was to try to ensure that that part of the Medicare Benefits Schedule was being used for genuinely urgent services, but we achieved the objectives in a different way.

Senator SIEWERT: Thank you. For those 20, what process do you go through when you modify them? Do you seek further advice? If so, who from?
Ms Shakespeare: The department will provide advice. The recommendations go from the committee directly to the minister. The minister then seeks input from the department. We will consult with a range of groups in terms of providing that advice: royal college in that area, the AMA, other societies if there are any and sometimes consumer groups. It really depends on the recommendations and what clinical area they're in.

Senator SIEWERT: Is it possible to get a list of what the 20 were?

Ms Shakespeare: We can take that on notice.

Senator SIEWERT: Is it possible to get a list of what the 20 were?

Ms Shakespeare: We can take that on notice.

Senator SIEWERT: That would be great. Just to be clear, are you taking on notice whether you can provide it or taking on notice that you will provide it?

Mr Simpson: That we will provide it.

Senator SIEWERT: I wasn't trying to be pedantic. I just didn't want to be disappointed with what I got! Could you tell me how much has now been spent on the review since it commenced in the 2017-18 budget?

Mr Weiss: Administered expenditure since the review first began—this is as at the end of August this year—is $34,715,709.

Senator SIEWERT: That's about $10 million under what was budgeted—is that correct?

Ms Shakespeare: There have been a couple of budget allocations here. The review is still to run until the end of the current financial year. That allocation was $44.2 million over three years. We're still spending money for the rest of this year. There are other committees still operating. We've had 70 clinical committees all up. Quite a few of them. It's a significant investment, but its over—

Senator SIEWERT: I'm merely asking. Where I wanted to go was: is this the end of the process, finishing up at the end of this financial year and no more money allocated, or are you going to do the rest of the—

Mr Weiss: The current agreed funding from the government does expire on 30 June 2020.

Senator SIEWERT: Which is in eight months time. And that is seen as the end of the review process?

Mr Weiss: That will certainly be the end of the task force part of the review. The clinician review part of it for the task force we expect will be finished by then. There will still clearly be implementation work of the task force's recommendations that will go beyond that date.

Ms Shakespeare: We need to think about the ongoing arrangements for making sure that the MBS remains up to date and represents clinical best practice. As I mentioned before, how we look at ongoing utilisation reviews, reviews after MSAC has recommended new items, is another thing that we have to continue doing to make sure that everything is—

Senator SIEWERT: It's ongoing?

Ms Shakespeare: Yes. It's a rolling exercise from here.

Senator SIEWERT: Is that what you anticipate doing next, looking at how the rolling process would operate? Would that be a correct interpretation?

Ms Shakespeare: Yes. We need to understand what will happen after the task force has finalised its work.
Mr Weiss: Part of the task force's terms of reference was to provide a recommendation to government about whether there should be some sort of ongoing review function, and the task force has discharged its obligations there and made a recommendation. That recommendation is yet to be considered by the government.

Senator SIEWERT: You pre-empted my next question! Is the consideration of those recommendations anticipated to be soon?

Ms Shakespeare: Yes.

Senator SIEWERT: Will it be publicly announced?

Ms Shakespeare: That will be a matter for government.

Senator SIEWERT: You may need to take some of this on notice. You referred to a figure of 70, but how many MBS review implementation committees have been formed?

Mr Simpson: Implementation liaison groups are the groups we set up after governments made a decision to assist with operationalising the recommendations of the task force.

Senator SIEWERT: Yes. Sorry, I'm confusing the two processes.

Mr Simpson: I haven't got those figures. It's a relatively low number at this point, but I haven't got the exact number with me.

Senator SIEWERT: Are there more still to be formed?

Mr Simpson: Yes.

Senator SIEWERT: Could you take on notice how many there are and how many you anticipate through the ongoing process?

Mr Weiss: The latter will be an estimate, but we can certainly give you our best guess going forward.

Senator SIEWERT: That would be great. Also how they will be funded and whether they will be budgeted in over the forward estimates.

Ms Shakespeare: That will be a matter for government after we get to 30 June. We are funding the work of the implementation liaison groups that are operating now out of that task force allocation.

Senator SIEWERT: So any ongoing work will be subject to a new allocation?

Ms Shakespeare: We'll need to have a government decision about that.

Senator SIEWERT: I'm chasing up the recommendations from the Royal Commission into the Protection and Detention of Children in the Northern Territory. I know I have to ask the bulk of them tomorrow in DSS, but the one that relates to the MBS Medicare items for young people in detention—have you given any consideration or been asked to give any consideration to that recommendation and the one that relates to access to the PBS?

Ms Shakespeare: I'm not sure where the whole-of-government process is up to there. We've certainly been asked for our views on that recommendation. Our views are that people in prisons, in incarceration, have their health best managed by the state and territory government that's responsible for the operation of the prison. That's the existing arrangement. Medicare Benefits Schedule provides benefits to privately practising doctors, nurses and allied health workers. It's very hard to coordinate them to deliver services to incarcerated people in prisons.
Senator SIEWERT: Have you looked at the recommendation from the royal commission?

Ms Shakespeare: Yes.

Senator SIEWERT: These are young people we're talking about who desperately need medical care, and they're not getting it properly. That's why the recommendation was made.

Ms Shakespeare: I think that the recommendation about their medical care is still addressed best by the government that's providing the services—the daily care services and the health services—to the prison population they're responsible for.

Senator SIEWERT: Have you spoken to the Aboriginal community controlled health services that are strongly supporting this recommendation?

Ms Shakespeare: They haven't spoken with DSS directly, no.

Senator SIEWERT: Have you spoken to them about it? Sought any of their opinions on this particular recommendation?

Ms Shakespeare: We'd also refer back to the Health Insurance Act, which does not allow the payment of MBS benefits where there is also an arrangement for payments for—

Senator SIEWERT: Acts can be changed.

CHAIR: It's a matter of policy.

Senator SIEWERT: Have you given any advice to government on it? I'm not asking what the advice was; I'm asking: have you given any advice to government on it?

Ms Shakespeare: Yes.

Senator SIEWERT: About the possibility of amending the legislation?

Ms Shakespeare: We can just confirm that we provided advice.

Senator SIEWERT: On both the MBS and the PBS? The recommendation extends to that.

Ms Shakespeare: Yes. They're covered by the same issues.

Senator SIEWERT: The pharmaceuticals extend to them as well. On both of those things, you provide advice?

Ms Shakespeare: To the best of my recommendation, yes.

Senator SIEWERT: Perhaps you could double-check on both.

Ms Shakespeare: Okay.

Senator SIEWERT: Thank you.

Senator DEAN SMITH: People have heard a lot about the government's success in listing medicines on the PBS, but it might be worthwhile getting on the record exactly how that listing process works and the various steps that must be gone through from a policy sense, but also I think from a legal sense, before a drug is listed. Then we will reflect, perhaps, on where we are up to, in terms of the total number of medicines that have actually been listed. For the sake of my Labor Senate colleagues, we might do a bit of compare and contrast. I have some quotes here from the previous Labor health minister that we might go to before I conclude my line of questioning. Can you lay out the process by which a medicine finds itself on the PBS?
Ms Platona: The PBS listing process has submission process. Anybody can make an application, but almost invariably the applicant is a pharmaceutical company. They hold the data and they have the evidence. An applicant lodges a submission. That application includes a number of claims: effectiveness, safety, cost and budget impact. That submission is assessed. It goes through a scripted and well-established process that affords natural justice to the applicant. It is transparent. There are assessment reports. They go back and forth between the applicant and various subcommittees, and eventually it's considered by the PBAC, the Pharmaceutical Benefits Advisory Committee. That process takes 17 weeks. It's a process that has been in place for many years. It's well-established and is one of the fastest assessment processes in the world. At the end of the 17 weeks—

Senator DEAN SMITH: So it's a world-class system, Ms Platona?

Ms Platona: We believe so. Yes. At the end of 17 weeks, there is a PBAC consideration. The PBAC has legislated requirements under the National Health Act about the matters that it takes into account.

Senator DEAN SMITH: Legislated matters that it must take into account and comply with?

Ms Platona: Correct. That's the role of the PBAC. The legislation is quite prescriptive about the role of the PBAC. It requires the PBAC to give advice to the government with respect to the comparative effectiveness and cost of the intervention in comparison with existing therapies. The PBAC is not permitted to make a positive recommendation if it is not satisfied that that intervention has better efficacy or safety or has some superior features to justify the higher price claimed. At the end of the PBAC's assessment, the committee has—

Senator DEAN SMITH: The PBAC assessment is within that 17-week period?

Ms Platona: Correct. The committee has three choices. It can accept the claim of the company in full, it can accept the claim of the company with some variations. These variations could be a lower price, a different population, or some other features—sharing arrangements, manage access arrangements—

Senator DEAN SMITH: So those variations, in the view of the PBAC, could possibly deliver better health outcomes for taxpayers in terms of a more competitive price?

Ms Platona: Correct—or reject. A final outcome that is possible is to defer and seek more information from the applicant and consider the application at the subsequent meeting. For a positive PBAC recommendation, whether accepted in full by the committee as claimed by the applicant or with some variations, there are subsequent steps, because having a positive PBAC recommendation is a mandatory step to enable the listing but is not a sufficient one.

Senator DEAN SMITH: It's not the end of the process.

Ms Platona: Indeed. Then the process continues. These are things that the department then works on: negotiation and agreement of price in line with the PBAC recommendation, compliance with the PBAC recommendation, agreement on the expected utilisation and cost to government with the pharmaceutical company and government agencies, finalisation of any eligibility restriction wording to assist administration by Services Australia and provision of all required listing documentation such as supply assurance by the pharmaceutical company. The company has to have available stock to sell from a certain date, re-share agreements,
legal documents, deeds of agreement that give effect to what is subject to contract law, financial approvals and so on for any PBS listing, with or without financial cost.

**Senator DEAN SMITH:** And those five or six elements that you have just reflected on are not constrained by a time period in the same way that—let me call it step 1—is constrained by the 17-week time period. I'm assuming that those five or six elements that you have just talked about require quite a degree of negotiation and argy-bargy, perhaps, on the part of the pharmaceutical company.

**Ms Platona:** The department works on all of those as quickly as possible. There are key activity indicators for completion of work, from price agreement to the actual end-budget impact listing. The key activity indicator in the portfolio budget statement says that the government has up to six months to list the medicines from price agreement and budget impact to listing, and we have reported on that key activity indicator at regular intervals.

**Senator DEAN SMITH:** Just to be clear, then: are there currently any medicines that have been recommended by the PBAC where the company has agreed to all of those necessary conditions, those five or six points that you have alluded to, and that are not yet listed?

**Ms Platona:** On the first of every month there is an update to the schedule, with new medicines being listed. The next update of the schedule is on 1 November. The medicines that have all completed the processes will be listed on 1 November. We have also completed processes, and the minister has approved the listing of the two cystic fibrosis drugs. One is a new drug, Symdeko, and the other is a broadening of the existing indication for Orkambi. Those have been announced and approved for 1 December. There are no other outstanding medicines that have completed all the necessary requirements at this point in time. The next update to the list is 1 December. The department has an internal working list from all the PBAC meetings that we are continuing to work through with each sponsor. On 1 December you will see new updates for products that we are working towards.

**CHAIR:** We are just about to go to a break.

**Senator POLLEY:** Can we move onto the PBS?

**CHAIR:** I was just waiting for Senator Smith to finish. When we come back, you are next on my list, Senator Polley. That is the intent; I was just trying to finish off these questions first. Do you have many more to go?

**Senator DEAN SMITH:** I am happy to go to the break and then come back for about five more minutes after.

**CHAIR:** If that is the case, we will have a short break.

**Proceedings suspended from 21:20 to 21:34**

**CHAIR:** We'll resume and we will go back to Senator Smith.

**Senator DEAN SMITH:** Thank you, Ms Platona. In summary, it's a two-step process. The first process is a 17-week process from the submission or submitter making the application to a recommendation from the PBAC. The second step—I'm paraphrasing now—is what's required to get the PBS listing in addition to the PBAC recommendation, and they are things like negotiation, agreement of price, agreement on the expected utilisation and cost to government, finalisation of any eligibility restrictions, wordings, provisions of all required

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documentation, risk sharing and legal agreement. That is the process. Just before we broke I asked you a question: were there any medicines that had been recommended by the PBAC and where companies had agreed to all the PBAC listing requirements that had not yet been listed or would not be listed? I think the answer to that was no.

**Ms Platona:** That's correct.

**Senator DEAN SMITH:** The answer to that was no.

**Ms Platona:** No.

**Senator DEAN SMITH:** Secretary, you might have seen the article in the News Corp papers from Sue Dunlevy. We talk about Sue Dunlevy articles quite regularly at Senate estimates. But this particular story in *The Daily Telegraph* is titled, 'The breakthrough cancer, mental health and arthritis medicines that will never be subsidised.' The article appears on 19 October. It starts by saying:

> News Corp can today reveal the secret list of medicines approved for government subsidy that have never made it on to the Pharmaceutical Benefits Scheme.

Are you familiar with that article?

**Ms Beauchamp:** I'm familiar with the article, yes.

**Senator DEAN SMITH:** Would you describe it as accurate or misleading?

**Ms Beauchamp:** I'd say it was misleading.

**Senator DEAN SMITH:** Misleading, not accurate.

**Ms Beauchamp:** I might let Ms Shakespeare talk more about clarifying.

**Ms Shakespeare:** I don't think there's any secret list. All of the PBAC recommendations are published, and we've regularly provided information to the committee here, which is also published, on notice about medicines that have been recommended by the PBAC and where the company may have decided not to proceed with listing. I think that is what is being characterised in the article. The government is limited in what it can do with a company not willing to list in accordance with PBAC recommendations. We attempt to list every medicine—

**Senator DEAN SMITH:** Limited because there's a legal requirement over the government.

**Ms Shakespeare:** That's exactly right; the National Health Act stops us from listing something where the company is unwilling to meet the requirements imposed by the PBAC.

**Senator DEAN SMITH:** They could be quality of care requirements—that is, the appropriate care of a patient that might utilise the drug—or it might be a cost to taxpayer consideration, or both.

**Ms Shakespeare:** Yes. The PBAC will be looking at comparative safety, comparative effectiveness and comparative cost effectiveness, and making recommendation based around those factors.

**Senator DEAN SMITH:** Great. Today Mr Bowen went out and made some comments reflecting on the conversation that we had earlier today at Senate estimates. He talks about the listing of drugs or the non-listing of some drugs. Mr Bowen says there are 80 drugs since the Liberals came to office which Australians do not have access to under the Pharmaceutical
Benefits Scheme because this government won't list them. Is that an accurate or inaccurate statement, given what we have just heard from Ms Platona in terms of whether or not there were any medicines outstanding to be listed.

**Ms Beauchamp:** I don't know about the statement. Indeed, I'm not sure where the 80 has come from in terms of the information we have provided to the committee today. Again, we can again clarify that information. I think probably the main point to note is that the time it takes for a medicine to be listed is mostly determined by the approach of the pharmaceutical company itself. In terms of our role in supporting the minister and the minister listing, we do everything we possibly can, but it really is up to the company that decides some of these time frames. But I'm not sure where the 80 is from.

**Senator DEAN SMITH:** I will provide you with a copy of the transcript and you can provide a response on notice. Let's be clear. I asked Ms Platona whether any medicines recommended by the PBAC where agreement had been reached with a particular company to meet all of the PBAC listing requirements had not yet been listed or would not be listed, and the answer was no. Turning to the government's record when it comes to the listing of drugs—how many new or amended drugs have been listed to date?

**Ms Shakespeare:** New or amended listings?

**Senator DEAN SMITH:** I think that we used one figure.

**Ms Platona:** In 2018-19, there were 338 new and amended medicines listed.

**Senator DEAN SMITH:** And the total to date since 2013?

**Ms Platona:** Since October 2013, it is 2,222.

**Senator DEAN SMITH:** Which is about 30 a month, or one a day.

**Ms Platona:** Correct.

**Senator DEAN SMITH:** Not that taxpayers would be concerned about this cost—I think most people would regard this as a good and necessary use of taxpayers' money—but what's the overall cost to the taxpayer?

**Ms Beauchamp:** I think for these ones, it was about $10.6 billion.

**Senator DEAN SMITH:** Finally, it has not always been the practice of governments to list drugs that have had a positive PBAC recommendation, though, has it?

**Ms Beauchamp:** Certainly it's government policy at the moment to list—

**Senator DEAN SMITH:** This government's policy, yes.

**Ms Beauchamp:** I'd have to refer to my colleagues.

**Senator DEAN SMITH:** Ms Shakespeare, you've been around—sorry, I don't mean that!

**Ms Shakespeare:** I have not been around that long!

**CHAIR:** It's getting late!

**Senator DEAN SMITH:** Ms Shakespeare, you've been around as long as Senator Siewert and me—perhaps longer—but you know what I mean.

**Ms Shakespeare:** I'm aware—not firsthand, of course—that there was a policy to not list I think seven medicines in 2012 until budget circumstances permitted or offsets were counted.
Senator DEAN SMITH: That's right. On 25 February 2011, Labor announced the unprecedented deferral of the listing of seven medicines under the PBS for conditions such as severe asthma, endometriosis and schizophrenia. The quote from Nicola Roxon, who was the health minister at the time—

Senator Watt interjecting—

Senator DEAN SMITH: on ABC—you'll enjoy this, Senator Watt—was:

Ultimately I think the important point is that we can't in every instance guarantee that a drug will be listed immediately because there are financial consequences for doing that…

Thank you very much, Ms Shakespeare. No more questions. Welcome back, Senator Watt.

Senator WATT: Good to be here. It's deja vu. Senator Smith was talking about this seven years ago, last time I was here, and he's still at it.

Senator DEAN SMITH: There's plenty more where that came from.

CHAIR: Senator Watt, have you got some questions to ask on outcome 4?

Senator WATT: I do. I want to talk about the PBS as well, because, listening to Senator Smith, you'd think everything's hunky-dory.

Senator DEAN SMITH: That's my job.

Senator WATT: It is your job, and you do it very well. But, unfortunately, there are a few other facts to be discussed as well. Are there any instances where a PBS listing has been announced by the minister without a final agreement being signed by the department and supplying company?

Ms Platona: I'm not aware of it.

Ms Shakespeare: Neither of us are aware of that.

Senator WATT: Could you take that on notice, and if there are any, could you please table—

Ms Shakespeare: How far back do you want us to check?

Senator WATT: Probably back to about 2013, I'd say.

Ms Shakespeare: We'll see what we can do.

Senator WATT: Thank you. Since October 2013, how many new PBAC recommended drugs or medicines have been listed on the PBS?

Ms Platona: The total is 2,222, which we spoke about earlier. I have the information here of high-cost listings. We have 27 from 2013 to date, which is part of this financial year. So there are 27 high-cost listings.

Senator WATT: Twenty-seven—

Ms Platona: High-cost, meaning the ones in excess of the threshold of $20 million in any financial year, which require cabinet consideration. New PBS listings—which mean a brand new molecule listed for the first time on the PBS or listed for the first time as a new indication—are 227. There are amended PBS listings, which include changing the restriction, adding a new form strength, changing the place in therapy from second line to first line and broadening of the listing—for example, listing a combination where individual components are already listed on the PBS. There are 298.
Senator WATT: But they're not new listings; they're amended listings.

Ms Platona: They are amended PBS listings.

Senator WATT: What I'm interested in is the new listings. We've had 27 plus 227, so far. Is that right?

Ms Platona: We have 227 new PBS listings. Some of the high-cost listings could have also been part of the new PBS listings.

Senator WATT: So that's it in total?

Ms Platona: That's correct. That's part of the 2,222.

Senator WATT: Sorry, what's that part of?

Ms Platona: Part of the total of 2,222.

Senator WATT: How many amended does that include?

Ms Platona: 298. Price changes, 316; and we have a number of listings that are with nil financial cost: 1,354.

Senator WATT: They're old listings, did you say?

Ms Platona: All of them are listings on the PBS since 2013.

Senator WATT: Yes. What I'm focusing on is new listings, not amendments to existing listings in 2013. New listings, for the first time since 2013, is roughly 227?

Ms Platona: Those are brand new molecules that have not been on the PBS ever or are a new indication for an existing drug.

Senator WATT: So when the minister is giving speeches, as he did last week, talking about 2,200 medicines being listed since October 2013, or one each day, he is overstatesing that by about 2,000. There's actually been about 200-odd.

Ms Shakespeare: I think the minister usually talks about new and amended listings.

Senator WATT: I don't think he did in that speech, did he?

Ms Shakespeare: The material that I usually see from the minister and the material that we provide to the minister about the PBS numbers is new and amended listings.

Senator WATT: So when the minister is talking about 2,200 medicines being listed since October, or one each day, he's talking about new and amended listings rather than new listings.

Ms Shakespeare: Yes, and he's usually very clear about that. We can show you plenty of media releases.

Senator Colbeck: I think it's worth making the point that a new listing would give new access to patients who wouldn't have had access to the medicines previously.

Senator HUGHES: Just so I can understand, a new listing of a drug that may previously have been available for breast cancer may now be available for those with melanoma or—

Ms Shakespeare: Gastric cancer.

Senator HUGHES: So it happens up to a whole new cohort, so, in effect, the drug is now open to a whole new group of people.

Senator Colbeck: An amended list
Senator HUGHES: So an amended listing will in effect open up a drug available to a whole new cohort of people.

Senator WATT: There's no argument from me that it's an amended listing, but it's not a new listing.

Senator HUGHES: It is a new listing if it's coming—

Senator WATT: It's not.

Senator HUGHES: if it's coming for a new use, if it's treating a cohort of people suffering from a particular disease.

Senator Colbeck: It is if you've got a disease that didn't have access to the drug previously.

Senator HUGHES: If we want to really get down to it, luckily for people, now these listings are at least occurring, unlike they did in 2013.

Senator WATT: I'm not saying it's not a good thing.

Senator DEAN SMITH: Call me old fashioned, but I quite like it when I hear the evidence from the officials.

Senator WATT: You'd better have a chat to your colleague over there. Can you confirm whether there have been 2,200 PBAC recommendations since October.

Ms Platona: The generics molecules—the new brands of generics—on the PBS are not assessed by the PBAC. There are generic brands of medicines listed on the PBS every month. They are not assessed by the PBS. All the other listings require the PBAC's consideration.

Ms Shakespeare: Price changes are also not usually considered by the PBAC. There will be some instances where we seek PBAC advice about whether a medicine price should be increased. We have two price-change processes, all of which require extensive assessment by officials in the department. If a company applies for a price increase, because it says the medicine is unsustainable at the price currently listed on the PBS, we have an assessment process for that. There's also price disclosure, which is a process that occurs every six months. It is a quite extensive process to assess and track the prices of medicines and what they're being supplied at in the market. So we have contractors that collect information about all discounts and prices at which medicines are being sold. That's then assessed by the department and checked to make sure that we have accurate weighted average prices compared with the PBS current listed price, and if there is a more than 10 per cent—or for some medicines more than 30 per cent—difference in price we then change the PBAC price. So there is quite an extensive process that we need to go through for that. Those are not assessed by the PBAC either, though.

Senator WATT: Thank you for that explanation. How many PBAC recommendations have there been since October 2013?

Ms Shakespeare: I think we'd need to take that on notice. It's all publicly available, but we haven't sat down and counted them up.

Senator WATT: This might be a better way to put it: how many PBAC recommendations were required for these 2,200 new and amended listings?

Ms Shakespeare: We'll have to go and check that.
Senator WATT: Okay. Are you able to confirm how many out of the new and amended listings are an identical medicine but a different brand?

Ms Platona: No, they wouldn't fit into that category.

Senator WATT: They wouldn't be included in the 2,200?

Ms Platona: Can you repeat the question, Senator?

Senator WATT: How many PBAC recommendations were required for the 2,200 new and amended listings?

Ms Platona: We'll take that on notice. And you had another question, Senator.

Senator WATT: Sorry; and how many of the new and amended listings are an identical medicine but a different brand?

Ms Platona: No, they are not there. An identical medicine that would be a new brand would be, by and large, a generic molecule and that would not go through the PBAC. There would be some companies that decide for their own on-patent drug to have a second brand, but that wouldn't be assessed by the PBAC and wouldn't be part of the new and amended listings. Perhaps I could use an example of what would be a new medicine versus an amended listing. I was going use the October list, because that is publicly available and it's the latest one. An example of a brand-new molecule that would be a new listing would be a drug called teduglutide, and that is a drug that has never been on the PBS before. An example of an amended listing is the listing of bevacizumab. That has been on the PBS before but it has been listed previously as second-line treatment. So on 1 October its use has been expanded into first-line use. That's an example of an amended listing. So people who could not have access to bevacizumab in a first-line setting will from 1 October be able to use this product; whereas before they could only use it in second-line, after failure of something else. So that's an example of an amended listing.

Senator WATT: Are you able to tell us when the minister last received advice on how many PBS listings there have been?

Ms Platona: I provided advice to the minister on 14 October.

Senator WATT: And that advice was that there had been around 2,200 new and amended listings since October 2013. Was that right?

Ms Platona: So I provided advice to the minister. That was on 14 October. There were no other positive PBAC recommendations for which the sponsors have indicated that they wish to proceed and which have met and completed all the listing requirements. We are updating the list on 1 November. We have completed the requirements for the cystic fibrosis drugs, and we are continuing to work on the next update to the list, which will be on 1 December.

Senator WATT: Could you please table a copy of that advice?

Ms Platona: Yes.

Senator WATT: Just to clarify for the record, I understand that the 80 drugs that Mr Bowen referenced today—and I think there's been some discussion of that while I've been away, are just a count of the list you tabled this morning. Is that correct?

Ms Shakespeare: We tabled a list in response to questions this morning.
Senator WATT: Yes. And the 80 drugs that Mr Bowen referenced—I understand there has been some discussion of this while I've been out of the room.

CHAIR: It was while you were here earlier, actually.

Senator WATT: Sure. But that list had 80 drugs on it.

Senator DEAN SMITH: What was the list?

Senator WATT: What was tabled this morning.

Ms Shakespeare: There was a list of medicines where the sponsor had advised the department that they did not intend to proceed with the PBS listing. That will be for a variety of reasons but we're not in a position to list those medicines.

Senator DEAN SMITH: So we can go back to Mr Bowen's statement, secretary, which said, '80 drugs since the Liberals came to office which Australians do not have access to under the Pharmaceutical Benefits Scheme because this government won't list them.' Is an inaccurate statement.

Ms Beauchamp: It is an inaccurate statement, yes.

Senator DEAN SMITH: It is an inaccurate statement.

Senator WATT: In what way is it inaccurate?

Senator DEAN SMITH: The shadow Labor health minister has made an inaccurate statement that will undermine public confidence in the listing of medicines—

Senator WATT: In what way is it inaccurate?

Ms Shakespeare: If the companies were willing to list these medicines on the PBS in accordance with the PBAC recommendations, we would action those. We would like to list them. Two of them are biosimilar brands of adalimumab, which will generate immediate savings for taxpayers of 25 per cent off the price of the second highest expenditure medicine on the PBS.

Senator WATT: But it is the case, isn't it, that the 80 drugs that Mr Bowen referenced is simply a count of the list that you tabled this morning?

Ms Beauchamp: I think—

Senator WATT: Nothing more than that.

Ms Beauchamp: I think the interpretation of that list is incorrect, because that's where the pharmaceutical company has decided not to continue to negotiate and agree a position that's consistent with a PBAC decision.

Senator WATT: Does that mean the government gets to take credit for listings but not for non-listings? Is that the way, Senator Smith—

Senator Colbeck: Senator Watt, if you'd been here when Senator Smith was asking—

CHAIR: You were actually in the room when Senator Smith was reading it.

Senator Colbeck: If you'd been here when Senator Smith was asking questions about the requirements—

Senator WATT: I was busy dealing with the Registered Organisations Commission—that body that you guys set up to go after unions and sent Michaelia Cash out with.
Senator Colbeck: Senator Smith asked a series of questions of the department around the process to bring a listing to fruition, which had a range of things, about six items, that had to occur subsequent to a PBAC decision. The committee took evidence on those, and those conditions that are part of the listing process are required to occur and, I think, form part of the advice that you're going to have tabled for you shortly—

Senator DEAN SMITH: So you made a mistake, Senator Watt.

Senator Colbeck: as you requested.

Senator WATT: I just had the Registered Organisations Commission demanding an apology from me! Can you believe that?

Senator Colbeck: Senator, there has been evidence put on the record this evening in relation to the process to finalise a listing, and my understanding is that that forms part of the advice that was given to the minister on 14 October.

Senator WATT: Okay.

Senator Colbeck: So that will be tabled for you to complete that process.

Senator WATT: Okay.

Senator Dean Smith interjecting—

Senator WATT: Thank you. My next questions in this outcome are about private health insurance.

Ms Beauchamp: Chair, have we finished PBS?

CHAIR: No, we've still got some time.

Senator WATT: Okay. I've got to be in another committee. Do you mind if I do private health?

CHAIR: As long as the officials are

Senator DEAN SMITH: Pay attention, Senator Watt, because Mr Bowen spoke about private health insurance!

Senator WATT: I'm very confident about that—very confident about that.

CHAIR: Are the officials happy to stay behind?

Ms Beauchamp: Yes.

Senator WATT: I want to begin by talking about an article by Dana McCauley in The Sydney Morning Herald on 23 July 2019. The article is headed 'Government's new plan to tackle health insurance premiums'. I have a copy here. But are you familiar with that article?

Ms Shakespeare: I'm not sure. From July, you say?

Senator WATT: Yes. If it's a new plan, it must be pretty well known, mustn't it? If it's real.

Ms Shakespeare: We're certainly continuing to work on reforms to private health insurance.

Senator WATT: I'll give you a copy. Sorry, I only have the one but we can get some more if needed. The article reports that the minister:

… has launched a fresh review of private health insurance that aims to reduce premiums and reverse declining membership …
Is that correct, that the minister has launched such a review?

Ms Shakespeare: We are working with stakeholder groups on further reforms to private health insurance, so the department has been meeting with private health insurers, representatives of hospital groups, the medical technology sector, consumers about private health insurance.

Senator WATT: So when exactly did the minister commission the review?

Ms Shakespeare: We've been talking with the minister for—well, it's sort of like a continuum, really. We've been reforming private health insurance for several years now. We're part way through reforms, shifting policies to gold, silver, bronze, basic.

Senator WATT: That's different. 'Ongoing inquiries' is different to launching a 'fresh review'.

Ms Shakespeare: No, we've been talking to the minister about further reforms we can look at to ensure that private health insurance remains affordable for Australians by keeping the costs of private health insurance down.

Senator WATT: Who's conducting this fresh review?

Ms Beauchamp: Could I just clarify: it's not a formal review as such. Minister Hunt has spoken about the second phase of the reform agenda and, as Ms Shakespeare said, he's actually welcoming comments from key stakeholders, but also working with and engaging with our key stakeholders, and we are too, on what might be possible and what some of those options might be, rather than formally commissioning a separate review as such.

Senator WATT: Right, so it's not really a fresh review?

Ms Beauchamp: Second phase.

Senator WATT: And what is the process for stakeholders and experts to provide input?

Ms Shakespeare: We have very frequent, continuous discussions with all people interested in private health insurance in terms of the key stakeholder groups.

Senator WATT: So you're approaching stakeholders?

Ms Shakespeare: Yes, and they're approaching us with their ideas too.

Senator WATT: And will there be a public consultation process?

Ms Shakespeare: There has been no commitment to a public consultation process.
Senator WATT: Private health insurance is obviously a matter of some public interest. Why wouldn't there be an opportunity for public input?

Ms Shakespeare: We've had fairly large-scale public input processes in the fairly recent past. I think we had an opportunity for all members of the public to provide their views to us on private health insurance, and we received 40,000 emails. So, we've had opportunities for public input on private health insurance options.

Senator WATT: And when will the review report to the minister?

Ms Shakespeare: We're providing options to the minister. We've already provided some advice to the minister.

Senator WATT: On things that can be done about private health insurance premiums?

Ms Shakespeare: Yes.

Senator WATT: When was the most recent time you did that?

Ms Shakespeare: I'd have to take that on notice, Senator.

Senator WATT: If you could, please. And without getting into what it says, have there been any recommendations made for cabinet consideration about private health insurance premiums?

Ms Beauchamp: Senator, I think at the moment we're busy collecting ideas and comments from a range of sources. Of course we have regular discussions with Minister Hunt on what ideas might be coming forward and what options are coming forward. There's nothing formal that has been put to government at this stage.

Senator WATT: The article quotes the minister as saying: I've already been meeting with private hospitals, insurers and medical leaders on the next stage in terms of private health insurance reforms … What is the timing for this next stage? Should we expect outcomes before the next premium increases on 1 April 2020, or is it more long term?

Ms Beauchamp: That will be a decision for the minister and for government.

Senator WATT: So no decision made on that at this point?

Ms Beauchamp: Not at this point in time.

Senator WATT: So the department's familiar with these meetings that the minister has described that he's been having?

Ms Beauchamp: Yes.

Senator WATT: Can you please take on notice the names of the organisations the minister has met with as part of this fresh review?

Ms Beauchamp: I would certainly have to take it on notice because there are probably some meetings he has had that I do not know about.

Senator WATT: Maybe it's better directed to the minister, then.

Senator Colbeck: I'm happy to take it on notice.

Senator WATT: Could you take on notice the organisations he's met with, how many times and when those meetings occurred, please. The department has had its own meetings as
Senator WATT: But are we talking about dozens of meetings or a handful of meetings?

Ms Shakespeare: Dozens.

Senator WATT: Starting when? He launched this review on 23 July in *The Sydney Morning Herald*, so I'm mostly interested in meetings that have occurred since then.

Ms Shakespeare: Since 23 July? Okay.

Senator WATT: Did the department know that the minister had launched a fresh review before you read about it in the paper?

Ms Shakespeare: Yes.

Ms Beauchamp: We have ongoing discussions with the minister about high-priority issues, and one of the high-priority issues for Minister Hunt is private health insurance. So we have a range of meetings with stakeholders on the core business of our department. Whilst we've taken it on notice, it's hard to separate what the meetings were about and for what specific purpose because part of our job is engaging with stakeholders, the industry, consumers, consumer peaks and the like.

Senator WATT: I'm not the one who described it as a 'fresh review' and made it into a thing.

Ms Beauchamp: I think he has spoken about the second phase of reform.

Senator WATT: The minister is also quoted in this article as saying:

*My goal is to continue to reduce the pressure on health insurance costs, but also to increase the value proposition … You can only do it by actually taking out cost drivers.*

What are the cost drivers as the department sees them?

Ms Shakespeare: I think they're set out in the Prudential Regulation Authority's reports on private health insurance. The key areas of cost are for hospital cover, accommodation, nursing benefits, medical benefits, doctors' fees and prosthesis benefits. Those are the categories that get reported there.

Senator WATT: And how might they be reduced?

Ms Shakespeare: We've been discussing a number of ideas with stakeholders. One of the options that's under consideration that's been suggested to us by some of the stakeholders is increasing use of the Hospital in the Home program, which would, for appropriate patients, allow them to rehabilitate in their own homes, which would benefit patients, as long as it is clinically appropriate, and would reduce costs of hospital accommodation.

Senator WATT: I'm not sure if this is the right outcome, but, since you mention Hospital in the Home, am I right that the rollout of that program isn't going particularly well?

Ms Beauchamp: Hospital in the Home?

Senator WATT: Yes. I thought that was one of those programs where—

Ms Beauchamp: I think you may be confusing the conversation we had earlier about Health Care Homes—
Senator WATT: No, I remember that very clearly. I thought Hospital in the Home was another program of this government that wasn't achieving.

Ms Beauchamp: Hospital in the Home is administered by state based services, but I think we spoke about Health Care Homes this morning.

Senator WATT: Health Care Homes? Okay. The article also reports that:

Mr Hunt told reporters on Tuesday that stakeholders have been asked to come individually with suggestions, but "ideally" he'd like them to "work together to identify any drivers that might have common ground".

What is the department doing to get stakeholders to work together to identify any drivers that might have common ground?

Ms Shakespeare: We have regular discussions with stakeholders. We encourage them to work not just directly with us but also with each other to come forward with innovative proposals that will improve the affordability of private health insurance but also the value proposition for consumers.

Senator WATT: What's the anticipated timing for the minister to approve annual private health insurance premium increases from 1 April 2020?

Ms Shakespeare: At this stage we are awaiting the insurers' premium applications, which we expect to arrive in mid-November. I think the due date is 12 November. Then hopefully an assessment process will be finished by the end of the calendar year.

Senator WATT: Would you expect to brief the minister on this pre Christmas or after Christmas?

Ms Shakespeare: Pre Christmas, definitely.

Senator WATT: Okay.

Ms Shakespeare: But then there can be several stages of application review.

Senator WATT: I have just a few questions about gold, silver, bronze. That has obviously had a lot of attention as well. Insurers were given between 1 April this year and 1 April next year to transition to the new gold, silver, bronze system. How many insurers have made the transition as of today? What are the most recent figures?

Mr Weiss: The data we have is that 36 insurers have either fully or partially implemented the gold, silver, bronze, basic conversion of their products.

Senator WATT: Have you got a breakdown for full and partial?

Mr Weiss: No, I don't.

Senator WATT: Could you take that on notice?

Mr Weiss: Yes.

Senator WATT: When is that as of?

Mr Weiss: 14 October, I'm told.

Senator WATT: Forgive my ignorance; how many insurers are there all up? That's 36 out of—

Mr Weiss: 37.
Senator WATT: Thirty-six out of 37. Do you know what proportion of policies that represents, because each insurer has multiple policies, don't they?

Ms Shakespeare: We have data as at 30 June 2019. Approximately 50 per cent had been categorised into the new product tiers, but there would have been an increase on that since 30 June.

Senator WATT: Does that mean that those ones have fully transitioned?

Ms Shakespeare: Yes. If they've been categorised into the new product tiers, they would be fully transitioned. What the partial implementation means is that some insurers may have transitioned some products but not other products.

Senator WATT: The aim of this reform, according to the minister, was to improve understanding and affordability. Is that right?

Ms Shakespeare: Yes.

Senator WATT: Is there any evidence to date that this has achieved those aims?

Ms Shakespeare: We now have 20 insurers offering discounts for people aged under 30. We also have 16 insurers offering higher voluntary excesses, which can make policies—

Senator WATT: Did you give me a number there?

Ms Shakespeare: There are 16 insurers offering higher voluntary excesses, which can help people, if they accept a higher excess, reduce the cost of their premiums.

Senator WATT: Yes, okay.

CHAIR: Senator Watt, I'm going to pass it to Senator Siewert. This is your last question.

Senator SIEWERT: I want to go to PBAC and ask about restraints. My understanding is that, in the August meeting, there were recommendations, if that's what you call them, or decisions made about risperidone, and that was something the department took to them. Is that correct?

Ms Platona: That's correct.

Senator SIEWERT: I will ask some questions around that. First, is that the only recommendation that was made around the use of chemical restraints?

Ms Beauchamp: No. I think we went through both the regulatory and non-regulatory components of what we were doing with restraints this morning—both physical and medication management. The PBAC is only one element of that, around risperidone.

Senator SIEWERT: Just risperidone?
Prof. Murphy: Risperidone is the only drug that's on the PBS with a recommendation for behavioural management of dementia, so it's the only drug that has a current PBS indication for that purpose.

Senator SIEWERT: I want to go to the advice in a minute. But that was the only advice that was given on the use of any chemical restraint; it was purely around the prescribing—and I'll get to that in a second—of risperidone. Is that correct?

Prof. Murphy: That's the only place that the PBAC has any influence over the prescribing of chemical restraints; it's the only PBS drug that's used in that indication. The PBS can't control off-label use of medication—other antipsychotics. It's a funding mechanism which can be used to help with control. But, in this situation, risperidone is the only drug listed on the PBS for the management of dementia. That's why I initiated that process to PBAC.

Senator SIEWERT: It was you?

Prof. Murphy: Yes.

Senator SIEWERT: The process then went to authorisation of it for 12 weeks.

Ms Platona: That's correct.

Senator SIEWERT: And it talks about 'authority required (streamlined)'.

Ms Platona: That's correct.

Senator SIEWERT: What does that mean?

Ms Platona: There are different levels of authority that prescribers would have to follow in order to get access to a PBS subsidy. Again, this is not about the appropriateness; it is about the subsidy. PBS is not here to regulate clinical practice; it is here to offer and provide a subsidy that is aligned with the best evidence in terms of clinical practice. This product, this medicine—the PBAC reviewed it in 2015 and again now, so it is not new for PBAC to review the subsidy for risperidone, which is the only one, amongst the many antipsychotic drugs that are on the PBS, that has specific indications for behaviour in dementia.

Senator SIEWERT: I'm reading off exactly what's on the website.

Ms Platona: Drugs are either unrestricted and can be used for anything, or they can be used for behaviour in dementia, disturbances in dementia. The level of authorities differ. Streamlining means that prescribers would have a code they would write on the prescription, and that would be processed by Services Australia. The next level up in terms of stringency is a phone authority. That means that, before a prescription can be written for that medicine, the prescriber has to ring Services Australia and seek an authority, and there is an authority number. So streamlining means that there is a code, and that code is the only requirement for the prescriber to make it available; they don't have to ring up Services Australia and seek an authority.

Senator SIEWERT: I understood what you said. But in the column that's termed, 'Listing requested by sponsor / Purpose of submission' it clearly says:

To seek advice about amending the current listing and establishing an additional authority code to reduce inappropriate use of risperidone to treat BPSD.

That's why I'm asking these questions.
**Prof. Murphy:** I can explain that. In the old system, there was an authority. The recommendation was to use it for 12 weeks, but there wasn't a block on a doctor just repeating it again. The intention was to put a specific new streamlined authority, with a lot of red-letter warnings, so that you couldn't use the standard authority. You'd have to agree to a range of conditions before you would continue it beyond 12 weeks—a clinical assessment, a review and a clear message that it was exceptional and unusual to use it beyond 12 weeks—whereas in the previous system, even though the recommendation was, 'You should only use it for 12 weeks,' you could just go in again and use that original code. The new process is: you won't be allowed to use the original code; you'll have to go through a process where you have to certify that you've gone through a whole lot of steps in assessing the patient before you get an ongoing prescription. That's the purpose of it. Again, it can't stop a doctor writing a private prescription. It's just another—

**Senator SIEWERT:** For something else, you mean?

**Prof. Murphy:** No, for risperidone. Any drug can be written—

**Senator SIEWERT:** This is only if they're claiming PBS?

**Prof. Murphy:** Yes. It's just a way of using the PBS funding system to help get that message through to doctors.

**Senator SIEWERT:** That's what I'm trying to get to. I'm not criticising it. I'm trying to find out more detail about it. And I seem to be getting a whole lot of blocks to me trying to find out what it's about.

**Prof. Murphy:** No, there are no blocks. It's about using the PBS to help control that doctor behaviour.

**Senator SIEWERT:** That's what I'm trying to understand. You said 'new streamlined process', and, when I hear 'new' I think, 'Have you changed the process or are you putting in terms of streamline as well?'

**Prof. Murphy:** A new block in, so, instead of using the old, basic authority, it's a new, different, much more stringent condition authority.

**Senator SIEWERT:** I'm not complaining about that; I'm trying to work out the detail of it. I understand that, if they wanted to not claim subsidy, that would be a different process. Also, in here it says, 'The proposed changes allowed the department to undertake retrospective utilisation analysis.' Has this new process come into effect?

**Ms Shakespeare:** No, there's a recommendation from the PBAC which needs to be actioned now by the government through the PBS listings process. That process is underway. I think it's important to note that the PBAC also recommended that there be a review of the utilisation of risperidone, no later than two years after we do make the changes through the Drug Utilisation Sub-Committee, to see if there is any change to other antipsychotics and benzodiazepines. That's quite important as well, because they are concerned that there might be a shift to off-label prescribing.

**Senator SIEWERT:** I read that, and that's what I wanted to ask about. It was only in August, so what's the time line for implementing that particular recommendation in terms of the extra authority needed, which I understand is a phone-in after 12 weeks?
Ms Shakespeare: We're working to implement those changes as quickly as possible. We need to go through processes, and I can't give you an exact date, but it will be as soon as possible, because this is a really important issue, and the department has sought these changes through its submission to the PBAC.

Senator SIEWERT: I'm not trying to be difficult. Is it a month, two months, six months? I don't know much about how long a recommendation like this would take to go through, because it's not as if it's about listing a drug; it's about changing the use or the prescribing of it. Can we expect to see it in a month, two months, three months?

Ms Platona: We need to work out the time line with our colleagues from Services Australia to put in place a new authority and the fastest way to do that. Three months is probably what we are realistically working towards.

Senator SIEWERT: On past experience, is that the usual time for this sort of change, where there's a change in the way it's prescribed?

Ms Platona: I'm hoping not to disappoint you. I'm saying three months.

Senator SIEWERT: Just after Christmas?

Ms Platona: Probably early new year, because we update lists. The next one is 1 December, and it's very unlikely to make the 1 December deadline.

Senator SIEWERT: Will the review of utilisation of those other drugs be built into the process when the announcement is made? Will that process already have been built in in the way you do that?

Ms Shakespeare: The Drug Utilisation Sub-Committee is a standing subcommittee of the PBAC. That will be added to its work program, and it will meet the recommendations of the PBAC around timing.

Senator SIEWERT: Has there been discussions with the commission and the aged-care section of the department about looking at using it to inform compliance activities?

Ms Shakespeare: Yes, we've certainly discussed this with the commission and with the aged-care part of the department.

Senator SIEWERT: There's a process then in place for looking at that on an ongoing basis? That information would be very useful—

Prof. Murphy: In the first instance—

Senator SIEWERT: Can you let me finish asking my question, please?

Prof. Murphy: Sorry.

Senator SIEWERT: Thank you. Will that compliance process be done before two years? It should start informing the process earlier than two years.

Ms Shakespeare: That is the Drug Utilisation Sub-Committee review. No, we will provide data to the aged-care part of the department and the commission about changes that we're seeing with the new items. The aged care part of the department have been very much involved in the submission to the PBAC. So we're very aware of it, and we'll get access to data more quickly than the Drug Utilisation Sub Committee review.
Senator SIEWERT: Professor Murphy, you were talking about how it doesn't stop other use of it. Is there a way to monitor the use of it outside of just asking providers how much of risperidone they're using that's not attracting the subsidy through the PBS?

Prof. Murphy: We think most of it is attracting a PBS subsidy. It's just whether it's used for that indication. There are other indications on the PBS for these drugs. One of the things we are going to do in terms of compliance activity is identify those GPs who work primarily in residential aged care and do what we've done in a number of other situations, which is to write to them, drawing attention to their high prescribing rates. There is probably not much prescribing, even though these drugs are cheap, but we don't know that they're all prescribed under that particular code. You can use other codes, which is why the other antipsychotics which aren't recommended for dementia can be used. But they are being used what is called 'off label'. They're being used for, say, management of schizophrenia or some other code which is inappropriate. We can track all that. We certainly will be very clearly targeting those doctors who have high prescribing rates.

Senator SIEWERT: Even if they're not on the PBS?

Prof. Murphy: Even if they're not using that code. We're trying to identify those doctors who have a strong residential aged-care practice and see if they've got a high prescribing rate. Dr Towler, who was here earlier, is doing a lot of work around that.

Senator SIEWERT: Could you take on notice a bit more detail around that process? I must admit I don't understand how you track the code if you're not doing it on the PBS.

Prof. Murphy: We are doing the PBS but, as I said, there are several indications for all of these drugs. Risperidone is the only one that has an indication for the behavioural management of dementia. But that doesn't stop people using them, unfortunately, without the right code.

Senator SIEWERT: So they're still using the other drugs on the PBS, but what if they're using risperidone outside of the PBS?

Prof. Murphy: That is harder to track.

Senator SIEWERT: That's what I want to also know: how you do that.

Ms Beauchamp: I think some of the other key data points in terms of collecting the information would include the Aged Care Quality and Safety Commission clinical governance guidance material, which will be reinforcing consent and appropriate documentation. They'll have information on their care plans on exactly what medication is being given to residential aged-care participants. But also we're looking at—and I think it came out of Professor Murphy's review—improving the capture of a unique residential aged-care service identifier in the PBS.

Senator SIEWERT: Sorry; could you say that again?

Ms Beauchamp: A unique residential aged-care service identifier.

Senator SIEWERT: That's what you're developing?

Ms Beauchamp: We're looking at collecting PBS data by residential service. I think with those two elements we'll have a pretty good opportunity to look at what data is being collected around individual care recipients, whether they're getting a PBS-subsidised medicine or not, as part of documentation around care plans.
Senator SIEWERT: How do they get the non-PBS data?

Ms Beauchamp: Through the care plans, but also, with the application of one of the quality indicators that we're working on, which is medication management, they'll be required to report.

Senator SIEWERT: Any use, whether it's PBS or not?

Ms Beauchamp: Yes, assuming we get that through.

CHAIR: Senator Siewert, I'm conscious of time. We've still got officials here from outcome 5 as well, and I notice that the opposition did have other questions.

Senator POLLEY: We've still got questions to go on outcome 4.

CHAIR: We'll keep going for a little while, but we're obviously conscious that we still have officials waiting to appear for outcome 5.

Senator POLLEY: We have some on outcome 5 as well. Do we have the call?

CHAIR: Senator Siewert?

Senator SIEWERT: I've got lots more questions but I will cede the call.

CHAIR: Are you happy to place any other questions on outcome 4 on notice?

Senator SIEWERT: Yes.

CHAIR: Thank you. Senator Griff is waiting to ask some questions on outcome 5, so could we please proceed very quickly?

Senator POLLEY: Okay. I want to go to Dental Services. To assist, I'll put all my questions on child dental benefits on notice. Can the department confirm that the current National Partnership Agreement on Public Dental Services for Adults expires on 30 June 2020?

Ms Edwards: Yes.

Senator POLLEY: Does this mean that there's no Commonwealth funding currently allocated to adult public dental from 1 July 2020?

Ms Edwards: It means that there's no funding under that agreement. What future arrangements will be in place are yet to be determined.

Senator POLLEY: Is the government planning to extend the national partnership beyond 30 June 2020?

Ms Edwards: The government will consider the options. In that regard, Minister Hunt wrote to his state and territory counterparts in the last week or so indicating that the department would soon be in contact to discuss further arrangements, and this is in accordance with an agreement that was stuck at the COAG Health Council some time ago to have discussions about future arrangements. So, rather than make any decision about the future or otherwise of that partnership, we're going to have some discussions about what the options are to best work with the states to help them with their responsibility to provide public adult dental health services.

Senator POLLEY: What's the time frame for those discussions?

Ms Edwards: We'll be making contact with the states and territories in the next couple of weeks, I imagine. I want to speak to them as quickly as possible. In the meantime, the team in
my group is having a look at what the options are so that we can have a fruitful discussion and then provide advice to government.

Senator POLLEY: Is it possible that we're going to have to wait until the May budget to find out or is there an announcement likely to be made before then?

Ms Edwards: We haven't had any discussions yet. I can't pre-empt when or how a decision will be made until we've at least talked to our state counterparts and provided advice to government.

Senator POLLEY: Minister, are you able to shed any light on whether or not there's going to be an agreement reached before the May budget?

Senator Colbeck: I think the evidence that you've just received is pretty extensive. At the end of the day, that will be a decision for government.

Senator POLLEY: So you're not aware of any time frame? There is some urgency in relation to dental care, that there is going to be services funded by—

Senator Colbeck: Ms Edwards has just outlined the process that we're about to undertake. It's a bit hard for me to give you an end date when the process is just commencing.

Senator POLLEY: Okay. We'll put the rest of ours—

Senator Colbeck: Understanding the time frames involved obviously.

CHAIR: Was that your final question, Senator Polley?

Senator POLLEY: I have one more. When is the COAG Health Council meeting when this will be discussed? When's the next planned meeting?

Ms Edwards: The next planned meeting of the COAG Health Council is 1 November, but this won't be discussed at that meeting because we're about to have discussions with officials. If it needs to be discussed by COAG health, it can be dealt with out of session or bilaterally or through some other mechanism or at a future meeting of the council.

Senator POLLEY: So is there another scheduled meeting after 1 November?

Ms Edwards: I'm not aware of when it's scheduled next year, but there'll be one proposed for early next year.

Ms Beauchamp: There's normally one earlier in the year and one later in the year.

Ms Edwards: Yes. But numerous items are dealt with out of session of the COAG Health Council, so whether there's a formal meeting or not shouldn't have any detrimental effect on progressing these discussions.

Senator POLLEY: So you're fairly confident then that things will be in place so that, as of 1 July 2020, there will be appropriate funding for adult dental health services?

Ms Edwards: As I said, we don't want to pre-empt what will happen in the discussions with the states and the best way to move this issue forward in a manner where we might be able to help the states with their responsibility to provide adult dental public health services. We care about it a lot. The states care about it a lot. I'm sure it will be a collaborative process. We'll progress it with all due haste.

Senator POLLEY: So you're expecting the public to have confidence that this government is going to continue funding it and that they're going to have access to the level of funding they currently do?
Ms Edwards: On the contrary, we're entering the discussions in an open and collaborative way to talk about the best ways to take long-term arrangements forward with the states and territories, so we're not pre-empting it in any way. We are looking forward to discussing with the states, as we've agreed with them, the best long-term arrangements for ensuring that adults receive public dental services.

Senator POLLEY: Is that doublespeak for ‘we want to reduce our funding and put the burden on the state governments’?

Ms Edwards: No.

Senator Colbeck: It's not doublespeak for anything. It's actually stating it as it is.

Ms Edwards: Open and collaborative discussion with the states and territories.

Senator POLLEY: Are you anticipating any funding cuts from the Commonwealth?

Ms Edwards: We're not anticipating any particular outcome. We're entering into discussions with the states and territories in an open and collaborative way in order to provide the best possible pathway forward for adult public dental health services.

Senator POLLEY: Thank you.

CHAIR: We've now concluded outcome 4 and we'll move to outcome 5.

Senator POLLEY: I'll place the rest of our questions on notice.

CHAIR: Thank you.

Ms Beauchamp: Chair, in the information we tabled for Senator O'Neill this morning I think we had an incorrect heading on one of the tables provided. I want to correct the record on that.

CHAIR: If you could, that would be great. Thank you.

Ms Shakespeare: The material handed up this morning had one page with a table entitled 'State percentage of patients with all special attendances bulk-billed'. That title is incorrect. It should be replaced with 'State bulk-billing rate for specialist attendances'.

CHAIR: Was that document being provided electronically?

Ms Shakespeare: It will be.

CHAIR: We haven't actually received it.

Ms Beauchamp: We might mark it as such.

CHAIR: If you could note the change on it as well, that would be great. Thank you very much.

[22:37]

CHAIR: I welcome officials from outcome 5. I'm going to start with Senator Griff since he has been waiting very patiently all evening.

Senator Griff: I'd like to refer to the use of pentobarbitone or Nembutal in a number of suicides of veterinarians and to today's recommendation, which you may or may not have seen, from the South Australian coroner that the liquid form of the drug be reclassified as a schedule 8 drug, rather than a schedule 4 drug. Dr Skerritt, as I understand it, the Poisons Act requires a schedule 4 drug to be stored in an area where the public do not have access and a schedule 8 drug to be kept in a locked container unless it's actually in use. You looked at that
in 2016 and decided that the current scheduling was appropriate. I also understand that the SA coroner's inquest last year heard that Nembutal was used in 293 suicides in Australia between July 2000 and June 2016 and a very high number of these, 33, were directly linked to veterinarian clinics, so a large proportion. Why is the injectable drug classified as a schedule 4 drug when the tablet form is listed as a schedule 8 drug? There are really two questions there. Are you reviewing it again or do you intend to review it based on the coroner's reports for South Australia and the recent one in Queensland, which you'd be aware of as well? Why is there a difference between the liquid and the tablet?

Dr Skerritt: I'll go to your second question first. The tablet form of pentobarbital is essentially not used in clinical practice these days. It was a sedative hypnotic and occasionally an adjunct anticonvulsant—it was usually a sleeping tablet—used in the fifties, sixties and seventies and was subject to abuse. So pentobarbital is essentially not used in routine human therapeutics; it is used in veterinary contexts.

The process for determining the scheduling of a drug—which determines, for example, whether it's locked up or not—is based on public consultation, advice from a statutory ministerial advisory committee of experts and then a decision by a senior medical officer. There was extremely strong opposition—with one or two exceptions, including submissions from coroners—from across almost all of veterinary practice for rescheduling of the product. Their arguments were as follows. Their first argument was the sheer volume of this product—especially when used in the euthanasia of large animals such as cattle and horses—and the practicality of locking it up. This would require locking it up while driving in a vehicle, for example, to a rural site where a horse might have to be euthanased. This made it impractical for the requirements for locking it up to be implemented. The second reason, they argued, was: guess who has the keys to these cupboards? Suicide is a tremendously sad event. But the keys to the cupboards are held by veterinarians and their staff. So the gist of the overwhelming number of submissions related to, first of all, practicality issues and, secondly, the fact that veterinarians would have the keys to the cabinets anyway. Then, when it went to the ministerial advisory committee—

Senator Griff: Doesn't it require two different people to actually—

Dr Skerritt: No, it doesn't. That's not a requirement in law.

Senator Griff: Okay.

Dr Skerritt: That advice from the public submissions went to the advisory committee. The advisory committee reflected on it and advised the department, and their advice was, 'impractical' and also 'the vets will have the keys anyway'. I must confess that, when the proposal was first made, I expected it to go a different way. But that was the overwhelming gist of the submissions and the advice of the advisory committee. We can relook at this at any time, either from a self-initiated view or from an application from any individual or organisation.

Senator Griff: Well, you have to wonder. There was the Queensland coroner and the South Australian coroner.

Dr Skerritt: Yes.
Senator GRIFF: And I think the interesting thing is that, according to the coroner's report, the Presiding Member of the Veterinary Surgeons Board of South Australia, for instance, Mr John Strachan—

Dr Skerritt: Did support it.

Senator GRIFF: Yes. The board supported the upscheduling of the drug. They now require SA veterinary hospitals to lock it up as though it was a schedule 8 drug.

Dr Skerritt: There's a difference between veterinary hospitals versus veterinary clinics.

Senator GRIFF: I understand that.

Dr Skerritt: The SA veterinary board only regulates the large hospitals.

Senator GRIFF: But here is an area that now requires it to happen because of the—

Dr Skerritt: Yes. And there are some others, and there were some veterinary stakeholders who did support it. But the majority did not support it. Those submissions are made public. They're on our website.

Senator GRIFF: So will you reconsider it?

Dr Skerritt: We can do so if we have a request. Or we can elect to do so. I'm happy to discuss this with the committee and the delegate. The issue will be: what has changed since 2017? Veterinarians would still hold the keys and the logistical issues of locking up large volumes are still there. I anticipate that, since they were the two strong issues back in 2017, they'll still be the issues that may render this impractical. But the question can be asked.

Senator GRIFF: Could you report back?

Dr Skerritt: I will.

Senator GRIFF: Okay. Great. Thank you. I have a stack of other questions, but I'll put them on notice.

CHAIR: Thank you very much. Senator Siewert.

Senator SIEWERT: I have some questions following up on the Senate inquiry into Lyme-like illnesses. Is it possible to get a table—which I have asked agencies to do previously in relation to Senate inquiry recommendations—showing where you're up to on each of the recommendations from the Senate committee?

Prof. Murphy: We can take that on notice.

Senator SIEWERT: You can take that on notice. I don't expect you to zoom it out of the air. I would like an up-to-date run-down on where you are against each of the recommendations.

Prof. Murphy: Yes.

Senator SIEWERT: That would be much appreciated. Can I go to the clinical pathways project? I understand that you've commissioned consultants. Is that correct?

Prof. Murphy: The work's completed—a draft clinical pathway. I reviewed it just a few days ago to send it out for broad consultation. So it's going out to consultation. It's a good document.

Senator SIEWERT: It's going out to stakeholders?

Prof. Murphy: To stakeholders for consultation.
Senator SIEWERT: Can I very quickly understand the process. You hired the consultants, who have done—

Prof. Murphy: They did some workshops with stakeholders and consulted a variety of groups, including stakeholders. They've drafted a clinical pathway, and that is now going out for consultation with all the stakeholders to make sure that they're happy with it.

Senator SIEWERT: How long is it going out for?

Prof. Murphy: Mr Boyley might have an idea.

Mr Boyley: I would need to take that on notice. It's a good question, because I haven't got that in my brief, and I have only just been reviewing it. It won't be out for a huge amount of time, but I'm happy to take on notice the exact period for you.

Senator SIEWERT: Okay, and what's the process from there? Does it go back to consultants or does the department or you, Professor, take it on from there in terms of finalising it?

Mr Boyley: The consultants have prepared it to this point; the department will take on the document from there with respect to any feedback. If there were a significant issue identified in stakeholder consultation that required substantial rewrite, we would then work with the consultants on that. But the process itself—it wasn't a matter of the department doing it at arm's length; we were involved with the consultants along the way, facilitating with respect to workshops, and giving and providing feedback along the way as well. So it was very much a matter of working with them. They had the ability to pull the pathways together, but then we had a variety of different specialists that were working through the guidance from there.

Senator SIEWERT: Okay, thank you. And you've only just received it?

Prof. Murphy: I only just approved it a few days ago, to go to consultation.

Senator SIEWERT: Okay, so it will go out shortly; thank you. I also understand that there's been work done on an education program. Is that correct?

Mr Boyley: That is correct. I'm just looking for the right part of my page. I'm happy to take your question.

Senator SIEWERT: Okay, thank you. Can I ask about the current status of that particular project.

Mr Boyley: Certainly. I'm hoping that I don't need to take it on notice, but I'm just checking. Apologies—I'm going to need to take that on notice. I'm not trying to avoid the question; I just don't have the brief in front of me.

Senator SIEWERT: I didn't take it that you were.

Mr Boyley: No, I'm just making sure—

Senator SIEWERT: You can't have everything there. Could you take on notice the current status of that project—

Mr Boyley: Absolutely.

Senator SIEWERT: how far progressed it is, how close to completion it is?

Prof. Murphy: This should probably be in the table that we'll provide you anyway, so we can put all that information in the table.
Senator SIEWERT: Fantastic; that would be great—and who's been consulted to date as well; that would be appreciated.

Mr Boyle: Yes, happy to.

Senator SIEWERT: I have had reports—and this came up during the inquiry—of suspension of medical practitioners who have been involved in providing medical support for people with Lyme-like, tick-borne, vector-borne illnesses. I'm wondering whether you keep an eye on that and whether you can provide us an update of how many doctors are involved and whether the process is ongoing.

Prof. Murphy: We wouldn't have direct information. That's a process that AHPRA or the medical board runs. There were a small number of practitioners, I think, who actually had restrictions on their practice rather than full suspensions. I know of at least one or two that were administering intravenous antibiotics in their consulting rooms in the absence of any evidence of infection. The medical board took that to be an inappropriate practice and put restrictions on their practice. That certainly caused some stakeholder upset, but it was seen to be quite unusual clinical practice to be administering intravenous antibiotics when there's no evidence of a proven bacterial infection, and there are risks associated with putting intravenous drips in someone in a GP's surgery. So the board took that view. We certainly get reports from the board, but the board is fiercely independent of government and works in its own way.

Senator SIEWERT: I understand that, and while investigations are ongoing APRA aren't going to tell me a lot. Do you get reports, after the fact, from APRA?

Prof. Murphy: APRA reports publicly the outcomes of its significant findings. We don't get a specific feed of that information.

Senator SIEWERT: Is there a way you can find out more information about the number of doctors?

Prof. Murphy: We could see if APRA will provide that information. They may or may not, but we can certainly ask them.

Senator SIEWERT: Can I ask you to take that on notice, to approach APRA, to see how many doctors there are and, within the bounds of the confidentiality of the process, what other issues APRA has taken action on? I know it's tricky.

Prof. Murphy: Yes.

Senator SIEWERT: That would be appreciated. I'll put the rest on notice. Thank you.

Senator LINES: Can the department, please, table all correspondence relating to the review of the self-testing IVD review and all correspondence relating to the company Ellume?

Dr Skerritt: That's a request for tabling, Senator. We certainly can do it. I should emphasise that I certainly—and I'm not aware of any of our staff having any interaction with this company, Ellume, directly. The requirement to review the self-testing framework was a legal one, because the current legislation—

Senator LINES: Yes. I'm just asking you to table the correspondence and any correspondence relating to Ellume. Did the Minister for Health ask the TGA to review the regulation of in vitro diagnostic medical devices in May of this year?
Dr Skerritt: No. The sequence of events was as follows. We get media requests all the time. In this case, a media request went to my colleague Brendan Murphy. He was asked to put out a statement explaining why self-testing, in the broad, with the exception of HIV and a few other things, was not permitted. Brendan realised it was a regulatory issue. And, in an exchange of emails to Brendan, I indicated, 'Hey, we're required to review this anyway. I wouldn't mind starting it a bit early,' because we're swept up with self-testing, a whole lot of things like do-it-yourself genetic tests, which have a lot of ethical, financial and legal issues associated with them. If you're tested to have a particular heritable disease you have to declare it in travel insurance and life insurance, for example. I intervened to say, 'Hey, I think we need to this earlier than, say, early 2020 because of the sheer complexity of the issue.'

Senator LINES: Given the time constraints, I'm sorry, can you table the date, and can you table the correspondence around that, please?

Dr Skerritt: Certainly. I can table correspondence that I have just referred to.

Senator LINES: Great. Did the department receive any requests to review this form of medical devices? You explained that. You had a media inquiry and that triggered—

Dr Skerritt: Yes. In my copy back to Brendan, Professor Murphy, a colleague, I copied the minister's office, which flagged that I was keen to do this consultation a bit earlier than normal. The minister's office came back a day or two later saying, 'Yes, that sounds like a good idea.'

Senator LINES: Did the TGA request approval from the Minister for Health?

Dr Skerritt: For any public consultation we conduct that could require a change to our regulations, even if they're regulations made as a delegate of the minister, we go to the minister's office. We also go to the minister's office with a consultation paper. That's appropriate, given these are regulations not administrative decisions.

Senator LINES: Was the department aware at any time that the chair of the company that manufactures influenza self-testing, Ellume, had donated almost $600,000 to the Liberal and National parties?

Dr Skerritt: I read it in the newspaper a few days after all this happened. I have not met this person and hadn't heard of them beforehand. It was all after the event. We were wanting to review self-testing.

Senator LINES: Can you confirm if there are any other instances where a minister has asked the TGA to review a banned device or substance?

Dr Skerritt: Banned is an inappropriate word. The reason self-testing was not permitted actually came out of a group of state and territory health ministers in the 2000s, when the technology wasn't very reliable and the support services were not available. It was on the advice of state and territory health ministers that these products were not approved for self-use.

But there are many cases in meetings with ministers and so forth where we discuss whether our regulatory framework is contemporary or not. It's the job of a good regulator to continue to have those discussions. We look at observations overseas. In June, when I visited and met with the other heads of medicines agencies I asked them about their self-testing frameworks because I became aware that Australia was very much out of date.
Senator ROBERTS: Thank you very much for coming here—

Dr Skerritt: I don't think we have a choice!

Senator ROBERTS: I have to make a short statement so that people understand the question. On 10 July Professor John McMillan, AO, and Emeritus Professor of Law at the ANU handed down a review into the operation of the Narcotic Drugs Act. That review made 26 recommendations to sort out the heavy-handed and unworkable regulations that have nobbled medical cannabis and hemp cultivation in this country. The basis of the report was a reinterpretation of the provisions of the United Nations Single Convention on Narcotic Drugs. Professor McMillan found there was no basis in the convention for the restrictive provisions that the Office of Drug Control has imposed in Australia and recommended a substantial deregulation of the rules around hemp and medical cannabis.

Without going through all 26 recommendations, let me raise the highlights. Recommendation 2 removes cannabidiol, CBD, including isomers and salts, from the definition of cannabis. This means that only the whole plant will be controlled during the growing stage through to processing, and only if that plant has above 0.3 per cent THC. That removes all hemp from regulation. This removes high-CBD compounds with low THC from regulation. Will you implement this recommendation?

Dr Skerritt: Senator, I believe that you've misinterpreted the recommendations from Professor McMillan.

Senator ROBERTS: In what way?

Dr Skerritt: His recommendations, firstly, were not to include only whole-plant medicinal cannabis within the regulatory framework. Secondly, he did not recommend that cannabidiol be excluded from regulation by either the TGA or the Office of Drug Control.

What he did was to propose to exclude cannabidiol, its isomers and its salts as a drug definition under the purposes of the Narcotic Drugs Act. This was actually because the Narcotic Drugs Act already adequately controls things such as these. So it was duplication between the act and the regulations. It's a rather technical point, but I do want to emphasise that the recommendations of Professor McMillan—which I should also add have all been accepted by government—

Senator ROBERTS: Sorry, have or—

Dr Skerritt: Have been: all 26 recommendations. They did not recommend that non-whole-plant cannabis and did not recommend that cannabidiol be taken out of the regulatory framework.

Senator ROBERTS: Okay, I'll take that and go back and do further research.

Dr Skerritt: I'm happy to provide a written explanation of this in more—

Senator ROBERTS: Can I come and have a chat with you?

Dr Skerritt: I'm happy to meet with you. We could ask Professor McMillan whether he would be prepared to come and meet too.

Senator ROBERTS: Where does the professor live?

Dr Skerritt: In Canberra.

Senator ROBERTS: Okay, thank you.
Senator DEAN SMITH: Dr Skerritt, I just want to be clear about the advice you gave to Senator Lines. You mentioned that you had copied the Minister for Health's office into an email exchange between yourself and the Chief Medical Officer.

Dr Skerritt: Yes.

Senator DEAN SMITH: And that was appropriate to do because you were consulting over regulations, not making administrative matters—

Dr Skerritt: Yes. I expressly sought the minister's office's— and, I guess, by default the minister's—approval to go forward a bit earlier with a consultation on a broad sweep of self-testing that was—

Senator DEAN SMITH: You sought their express permission?

Dr Skerritt: It's a question that we asked in mid-2019. Normally, I'd only be asking about now, but we wanted to get going a few months earlier because, as I indicated earlier, this is pretty complicated. Everyone is talking about influenza tests, but there is a wide range of tests for other diseases, for serious medical conditions and for things like genetic testing. So it's very complicated.

The consultation is open now. There is a paper on our website; I think it's been open since 27 September. I think it closes on 22 November.

Senator DEAN SMITH: Excellent, thank you.

CHAIR: I think that's all the questions now. There being no further questions at this time the committee's consideration of the Health portfolio will conclude. The committee will resume tomorrow, Thursday 24 October, with examination of the Social Services portfolio, including Services Australia.

I thank Minister Colbeck, as well as officers from the Department of Health and agencies which have given evidence to the committee today. I declare the hearing adjourned.

Committee adjourned at 22:59