COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Estimates

(Public)

THURSDAY, 10 NOVEMBER 2022

CANBERRA

BY AUTHORITY OF THE SENATE

[PROOF COPY]

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Thursday, 10 November 2022

Members in attendance: Senators Antic, Askew, Cadell, Canavan, Marielle Smith, McGrath, McKenzie, Nampijinpa Price, David Pocock, Pratt, Rennick, Reynolds, Rice, Roberts, Ruston, Steele-John, Tyrrell, Urquhart, Waters and Whish-Wilson

HEALTH AND AGED CARE PORTFOLIO

In Attendance

Senator Gallagher, Minister for Finance, Minister for the Public Service, Minister for Women

Senator McCarthy, Assistant Minister for Indigenous Australians, Assistant Minister for Indigenous Health

Department of Health and Aged Care

Whole of Portfolio

Professor Brendan Murphy AC, Secretary

Professor Paul Kelly, Chief Medical Officer, Chief Medical Officer Group

Mr Charles Wann, Chief Operating Officer, Deputy Secretary, Corporate Operations Group

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

Mr Ian Scensor, First Assistant Secretary, Information Technology Division

Ms Jackie Davis, First Assistant Secretary, Legal and Assurance Division

Mr Paul McCormack, First Assistant Secretary, Financial Management Division

Mr Andrew Godkin, First Assistant Secretary, Office for Sport

Mr Stephen Bouwhuis, Assistant Secretary, Legal and Assurance Division

Mr David Hicks, Assistant Secretary, Financial Management Division

Mr Sean Lane, Assistant Secretary, Financial Management Division

Mr John Boultbee, Chief Executive Officer, National Sports Tribunal

Outcome 1

Professor Brendan Murphy AC, Secretary

Professor Paul Kelly, Chief Medical Officer, Chief Medical Officer Group

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

Ms Penny Shakespeare, Deputy Secretary, Health Resourcing Group

Ms Tania Rishniw, Deputy Secretary, Primary and Community Care Group

Mr Blair Exell, Deputy Secretary, Strategy, Evidence and Research Group

Ms Bronwyn Field, First Assistant Secretary, Portfolio Strategies Division

Ms Allyson Essex, Acting First Assistant Secretary, Portfolio Strategies Division

Mr Gavin Matthews, First Assistant Secretary, First Nations Health

Dr Phillip Gould, First Assistant Secretary, Health Economics and Research Division

Dr Masha Somi, Chief Executive Officer, Health Economics and Research Division

Ms Tracey Duffy, First Assistant Secretary, Medical Devices and Product Quality Division

Ms Stefanie Janiec, Acting First Assistant Secretary, Regulatory Practice and Support Division

Mr Nick Henderson, Acting First Assistant Secretary, Medicines Regulation Division

Dr Bridget Gilmour-Walsh, Principal Legal and Policy Adviser, Health Products Regulation Group

Dr Robyn Langham, Chief Medical Adviser, Health Products Regulation Group

Dr Lucas de Toca, First Assistant Secretary, Vaccine Policy, Implementation and Primary Care Response

Ms Trish Garrett, First Assistant Secretary, Vaccine Operations and Data Division

Ms Emily Harper, Acting First Assistant Secretary, Office of Health Protection and Response Division

Ms Sarah Norris, Acting First Assistant Secretary, Office of Health Protection and Response Division

Ms Celia Street, First Assistant Secretary, Population Health Division

Mr Mark Roddam, First Assistant Secretary, Mental Health and Suicide Prevention Division

Ms Lisa Schofield, First Assistant Secretary, Cancer, Hearing and Program Support Division

Mr Simon Cottrell, First Assistant Secretary, Primary Care Division

Mr Travis Haslam, Acting First Assistant Secretary, Medical Benefits Division

Ms Adriana Platona, First Assistant Secretary, Technology Assessment and Access Division

Mr Matthew Williams, First Assistant Secretary, Health Workforce Division

Ms Fifine Cahill, Assistant Secretary, Portfolio Strategies Division

Ms Clare Firth, Assistant Secretary, Portfolio Strategies Division

Mr Adam Cullen, Acting Assistant Secretary, Health Economics and Research Division

Ms Tiali Goodchild, Assistant Secretary, Population Health Division

Ms Belinda Roberts, Assistant Secretary, Population Health Division

Mrs Anthea Raven, Assistant Secretary, Mental Health and Suicide Prevention Division

Mr Chris Bedford, Assistant Secretary, Primary Care Division

Mr Nigel Murray, Assistant Secretary, Medical Benefits Division

Ms Mary Warner, Assistant Secretary, Technology Assessment and Access Division

Mr Simon Cleverley, Acting Assistant Secretary, Benefits Integrity and Digital Health Division

Mr Martin Rocks, Assistant Secretary, Health Workforce Division

Mr Jonathan Bray, Assistant Secretary, Health Workforce Division

Ms Louise Clarke, Assistant Secretary, Health Workforce Division

Mr Pat Janek, Assistant Secretary, Health Workforce Division

Dr Andrew Singer, Principal Medical Adviser, Health Workforce Division

Professor Alison McMillan, Chief Nursing and Midwifery Officer, Chief Nursing and Midwifery Officer Division

Professor Michael Kidd, Deputy Chief Medical Officer and Principal Medical Adviser, Deputy Chief Medical Officers Division

Dr Sonya Bennett, Deputy Chief Medical Officer, Deputy Chief Medical Officers Division

Australian Commission on Safety and Quality in Health Care

Ms Naomi Poole, Acting Chief Operating Officer

Dr Carolyn Hullick, Clinical Director

Mr Mike Wallace, Principal Adviser, Clinical Director

Australian Digital Health Agency

Ms Amanda Cattermole, Chief Executive Officer

Mr Paul Creech, Chief Program Officer

Ms Lisa Rauter, Chief Operating Officer

Dr Mal Thatcher, Chief Technology Officer

Australian Institute of Health and Welfare

Mr Rob Heferen, Chief Executive Officer

Mr Matthew James, Deputy Chief Executive Officer

Australian Health Practitioner Regulation Agency

Mr Martin Fletcher, Chief Executive Officer

Ms Kym Ayscough, Executive Director, Regulatory Operations

Dr Jamie Orchard, General Counsel

Food Standards Australia New Zealand

Dr Sandy Cuthbert, Chief Executive Officer

Mr Glen Neal, General Manager

Mrs Christel Leemhuis, General Manager

Mrs Luci Henson, General Manager

National Health and Medical Research Council

Professor Anne Kelso, Chief Executive Officer

Ms Clare McLaughlin, General Manager

Dr Julie Glover, Executive Director

Ms Prue Torrance, Executive Director
Mr Alan Singh, Executive Director
Ms Katie Matthews, Acting Executive Director

National Health Funding Body

Mr Shannon White, Chief

Office of the National Rural Health Commissioner

Adjunct Professor Ruth Stewart, National Rural Health Commissioner

Organ and Tissue Authority

Ms Lucinda Barry, Chief Executive Officer
Ms Belinda Small, Chief Operating Officer

Professional Services Review

Ms Linnet Lee, Chief Financial Officer
Mr Bruce Topperwien, Executive Officer and General Counsel
Mr Andrew Shelley, Special Counsel
Dr Antonio Di Dio, Acting Director

Outcome 2

Professor Brendan Murphy AC, Secretary
Professor Paul Kelly, Chief Medical Officer, Chief Medical Officer Group
Ms Penny Shakespeare, Deputy Secretary, Health Resourcing Group
Ms Tania Rishniw, Deputy Secretary, Primary and Community Care Group
Ms Lisa Schofield, First Assistant Secretary, Cancer, Hearing and Program Support Division
Mr Simon Cottrell, First Assistant Secretary, Primary Care Division
Mr Travis Haslam, Acting First Assistant Secretary, Medical Benefits Division
Ms Adriana Platona, First Assistant Secretary, Technology Assessment and Access Division
Mr Daniel McCabe, First Assistant Secretary, Benefits Integrity and Digital Health Division
Ms Louise Riley, Assistant Secretary, Medical Benefits Division
Ms Renaye Lucchese, Assistant Secretary, Medical Benefits Division
Mr Brian Kelleher, Assistant Secretary, Medical Benefits Division
Mr Nigel Murray, Assistant Secretary, Medical Benefits Division
Ms Mary Warner, Acting Assistant Secretary, Technology Assessment and Access Division
Mr David Laffan, Assistant Secretary, Technology Assessment and Access Division
Ms Elizabeth Flynn, Assistant Secretary, Technology Assessment and Access Division
Ms Natasha Ploenges, Assistant Secretary, Technology Assessment and Access Division
Mr Nikolai Tsyganov, Assistant Secretary, Technology Assessment and Access Division
Mr Ben Sladic, Assistant Secretary, Benefits Integrity and Digital Health Division
Ms Hongxia Jin, Assistant Secretary, Benefits Integrity and Digital Health Division
Mr Harry Rothenfluh, Assistant Secretary, Benefits Integrity and Digital Health Division
Ms Catherine Riordan, Acting Assistant Secretary, Benefits Integrity and Digital Health Division

Outcome 3

Professor Brendan Murphy AC, Secretary
Professor Paul Kelly, Chief Medical Officer, Chief Medical Officer Group
Mr Michael Lye, Deputy Secretary, Ageing and Aged Care Group
Dr Nick Hartland, First Assistant Secretary, Home and Residential Division
Ms Helen Grinbergs, First Assistant Secretary, Service Delivery Division
Ms Amy Laffan, First Assistant Secretary, Quality Assurance Division

Ms Eliza Strapp, First Assistant Secretary, Market Workforce Division
Ms Thea Connolly, First Assistant Secretary, Reform Implementation Division
Mr Russell Herald, Assistant Secretary, Home and Residential Division
Mr James Benson, Assistant Secretary, Home and Residential Division
Mr Mark Richardson, Assistant Secretary, Home and Residential Division
Ms Chris Jeacle, Assistant Secretary, Service Delivery Division
Ms Cathy Haffner, Acting Assistant Secretary, Service Delivery Division
Mr Jacob Madden, Assistant Secretary, Service Delivery Division
Ms Chloe Stoddart, Assistant Secretary, Service Delivery Division
Ms Megan Lancaster, Assistant Secretary, Service Delivery Division
Ms Caroline Turnour, Acting Assistant Secretary, Quality Assurance Division
Ms Mel Metz, Assistant Secretary, Quality Assurance Division
Ms Katie Holm, Assistant Secretary, Quality Assurance Division
Mr Joshua Maldon, Assistant Secretary, Quality Assurance Division
Mrs Chamandeep Chehl, Assistant Secretary, Quality Assurance Division
Ms Emma Gleeson, Assistant Secretary, Market Workforce Division
Mr Robert Day, Assistant Secretary, Market Workforce Division
Mrs Alice Creelman, Assistant Secretary, Market Workforce Division
Ms Ingrid Leonard, Assistant Secretary, Market Workforce Division
Mr George Masri, Assistant Secretary, Market Workforce Division
Ms Michelle Steele, Assistant Secretary, Market Workforce Division
Mr Greg Pugh, Assistant Secretary, Reform Implementation Division
Mr Greg Keen, Assistant Secretary, Reform Implementation Division

Aged Care Quality and Safety Commission

Ms Janet Anderson, Commissioner

Independent Health and Aged Care Pricing Authority

Ms Joanne Fitzgerald, Acting Chief Executive Officer
Ms Olga Liavas, Executive Officer

Outcome 4

Professor Brendan Murphy AC, Secretary
Professor Paul Kelly, Chief Medical Officer, Chief Medical Officer Group
Mr Charles Wann, Chief Operating Officer, Deputy Secretary, Corporate Operations Group
Mr Andrew Godkin, First Assistant Secretary, Office for Sport
Mr John Boultbee, Chief Executive Officer, National Sports Tribunal

Australian Sports Commission

Mr Kieren Perkins OAM, Chief Executive Officer

Sport Integrity Australia

Mr David Sharpe APM OAM, Chief Executive Officer
Ms Anne-Marie Phippard, Acting Deputy Chief Executive Officer
Ms Rebecca Tyler, Chief Financial Officer
Ms Shelley Ray, Executive Officer

Australian Sports Foundation

Mr Patrick Walker, Chief Executive Officer
Mr Ricardo Piccioni, Head of Government and Stakeholder Relations

Committee met at 09:00

CHAIR (Senator Marielle Smith): I declare open this meeting of the Senate Community Affairs Legislation Committee. I begin by acknowledging the traditional custodians of the land on which we meet today and pay my respects to their elders past, present and emerging. I extend that respect to Aboriginal and Torres Strait Islander peoples here today. The committee is due to report to the Senate on Tuesday 29 November 2022, and it has fixed Friday 16 December 2022 as the date for the return of answers to questions taken on notice. The committee would appreciate it if senators could provide any written questions on notice to the secretariat by Friday 18 November 2022.

The committee's proceedings today will begin with the health policy, access and support outcome of the Health and Aged Care portfolio. Under standing order 26, the committee must take all evidence in public session. This includes answers to questions on notice. I remind all witnesses that, in giving evidence to the committee, they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee, and such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence.

The Senate has endorsed the following test of relevance of questions at estimates hearings. Any questions going to the operations or financial positions of the departments and agencies which are seeking funds in estimates are relevant questions for the purposes of estimates hearings.

I remind officers that the Senate has resolved that there are no areas in connection with the expenditure of public funds where any person has a discretion to withhold details or explanations from the parliament or its committees unless the parliament has expressly provided otherwise.

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

Witnesses are reminded of the Senate order specifying the process by which a claim of public interest immunity should be raised. I incorporate the public immunity statement into *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)

Department of Health and Aged Care

[09:03]

CHAIR: I welcome Senator the Hon. Malarndirri McCarthy, Assistant Minister for Indigenous Australians and Assistant Minister for Indigenous Health, representing the Minister for Health and Aged Care, the Hon. Mark Butler MP. Minister, do you have an opening statement for the committee?

Senator McCarthy: I just want to say good morning and also acknowledge the Ngunnawal and Ngambri peoples, onto whose country we come, and I pay my respects as well to their elders past and present.

CHAIR: I also welcome back to our committee Professor Brendan Murphy, the Secretary of the Department of Health and Aged Care. Professor Murphy, do you have an opening statement for the committee?

Prof. Murphy: No, but we do have a little bit of information that we said we would report back to this committee on from Tuesday night. Mr Wann and Mr Exell have some brief information to relay at the start. The only other thing I would say is that there are a lot of portfolio agency people in this outcome. They're all very happy to wait around until their time, but if any senator just has one question for one agency we'd be happy to accelerate that in the program if that suits; otherwise they will wait for their turn.

CHAIR: Professor Murphy, we will go to these colleagues. Before we do that, if I can, I might just indicate how I intend to manage the program this morning. We do have a number of agencies which we are only seeing this morning. With the committee's agreement, I would like to work through those agencies first so that we can release them and then continue on with the outcome. I intend to call AHPRA first. Whilst you're making those statements, if AHPRA wants to shuffle ahead.

Mr Wann: There was a number of questions we said we'd try to come back to you today on with a bit more detail. First, in relation to terminations, we've examined the data for ongoing and non-ongoing staff for the period since 21 May 2022. In summary, there have been 20 staff terminated since 21 May 2022. Four of these were non-ongoing staff, and 16 were ongoing staff. For the non-ongoing staff, the reason for termination was their duties are no longer available. For example, a function was related to the pandemic response work. Most of the terminations of ongoing staff were actually voluntary redundancies. There were 10 of them. The remainder were performance related or due to the staff member not having the ability to perform their duties because of physical or mental incapacity or for failure to satisfy probation requirements. Senator Ruston, you also asked in relation to contractors. Unfortunately our systems don't enable us to report easily on contract determinations. It would take quite a lot of work to pull that together manually. We can look to do it, but we'd just have to see what's involved in trying to interrogate all of the various systems to get that information.

Senator RUSTON: I'll seek to refine it down a little for you so that it will be a bit easier. While we're on this section, I have also a couple of follow-up questions from some answers that were given on Tuesday night in this area. Do you want me to do them now?

CHAIR: I'm happy for you to do them now, and then we'll be moving to AHPRA.

Senator RUSTON: In response to this line of questioning on Tuesday night, the department said that, to the best of your knowledge, you weren't aware of any code of conduct complaints. To be really specific, have you received, and if so how many, APS code of conduct complaints that have been lodged by external stakeholders, say, by patient groups or the like, against departmental officials?

Prof. Murphy: I think there was one external person, one external agency, who claimed a code of conduct, which is being investigated. We can't really go into detail, but Ms Balmanno might be able to provide some

information on that. There certainly was one allegation of a code of conduct breach from an external party in relation to I think a funding arrangement.

Ms Balmanno: In terms of the code of conduct, we can receive allegations or complaints from external parties. We look into those, obviously, but in terms of the actual investigation of the code of conduct breach or the finding of a code of conduct breach, that happens within the department. They will allege certain behaviour and we will then investigate it against whether it be public interest disclosure or code of conduct or whatever we think it warrants.

Senator RUSTON: How many of those—

Prof. Murphy: I think there was one such allegation.

Ms Balmanno: There has been at least one. I would have to check whether there have been any others.

Senator RUSTON: If you could provide us with details of how many, I suppose, complaints against officials that you have received from external?

Ms Balmanno: Certainly. Over the last—

Senator RUSTON: It's pretty serious for somebody to make a complaint. I'd also like to know, if complaints were made, were any findings made by the department? I'm more interested in whether the department actually found that the allegations were able to be substantiated and upheld, and then seek to know what the action of the department was in relation to that. In investigating this—you're only talking about one, so clearly you'll be able to answer yes or no pretty easily on this one—have you received a complaint in relation to the conduct of an official in your department who is either currently in either of the minister's offices or was previously in any of the current ministers' offices?

Ms Balmanno: The one I have in mind—the answer is, no. If there are others, I'd have to take that on notice.

Senator RUSTON: Has the department engaged any external organisation to investigate any complaints?

Ms Balmanno: Yes, we often engage external investigators to make sure that there is not a sense of bias with the organisation conducting its own investigation.

Senator RUSTON: Has the department ever engaged Clayton Utz?

Ms Balmanno: I would have to take that on notice.

Senator RUSTON: If it would be possible for us to get that today, that would be great.

Ms Balmanno: Certainly.

Senator RUSTON: Does the department have any conduct policy in terms of the department's expectation around how the officials of the department conduct themselves when they engage with external organisations?

Ms Balmanno: Yes, in that we are bound by the Australian Public Service Code of Conduct.

Senator RUSTON: I'm assuming the department would take particularly seriously an allegation that came from an external stakeholder?

Ms Balmanno: Definitely, yes.

Senator RUSTON: If we could get some information specifically back around that today that would be really good.

Ms Balmanno: Okay.

CHAIR: We'll now be moving to—

Prof. Murphy: Mr Wann hasn't finished his feedback. Senator Ruston would not want to miss out.

Mr Wann: The senator also asked about some major structural changes since the annual report. In summary, the major changes are the three COVID vaccine program divisions moved from the Operation COVID Shield task force and reduced to two divisions. The First Nations Health Division moved to the Strategy, Evidence and Research Group. Previously that was the Indigenous Health Division under the Primary and Community Care Group. The Chief Nursing and Midwifery Officer moved to the Health Resourcing Group. The Cancer, Hearing and Program Support Division was renamed the Cancer, Hearing and Chronic Conditions Division. A health equity branch was established as a new branch in the Population Health Division.

You also asked whether we could confirm detailed movements of funds, and we took that on notice and said we'd try to get back to you today. I can confirm that it was quite a large movement; $2.35 billion was moved into 2022-23. The main contributors were, as we thought, $1.8 billion in program 1.8, related to the National Medical Stockpile, vaccines and treatments. There was a second large but significantly smaller movement of $274 million in aged care, program 2.3, related to sector support. The next largest was significantly smaller, $23 million in

mental health, program 1.2, related to emergency response supports. I would just like to clarify some evidence provided in relation to departmental staff seconded to ministerial offices. I can confirm there are no departmental staff backfilling roles in Minister Wells's office. They're all of the questions that I had. My colleague had one on international travel.

Mr Exell: The senator asked a question about international travel. The Assistant Minister for Mental Health and Suicide Prevention travelled to Italy via the UK for the World Health Organization's Global Mental Health Summit from 10 to 17 October. The Minister for Sport and Minister for Aged Care travelled to New Zealand from 20 to 23 October for the Australia New Zealand Sports Law Association Conference, and also participated in the FIFA Women's World Cup Australia New Zealand 2023 official draw release. The Assistant Minister for Indigenous Australians and Assistant Minister for Indigenous Health travelled to Indonesia for the G20 Health Ministers meeting from 26 to 29 October. As to any non-portfolio travel, the Assistant Minister for Indigenous Australians and Assistant Minister for Indigenous Health travelled to Fiji from 12 to 15 October for the Pacific Women's Leaders Governance Board meeting.

Senator RUSTON: I asked for the costs associated with that, but you don't have to do that now.

Mr Exell: I don't have the costs but we can get that.

Senator RUSTON: Take that on notice.

CHAIR: I'm keen to move to AHPRA at the moment. We have two senators with single blocks of questions, which I'll seek to deal with first, and then I'll come to you, Senator Ruston, once we've cleared those. If senators do have questions for AHPRA, could you let me know so we can dismiss them after now.

Australian Health Practitioner Regulation Agency

[09:15]

Senator URQUHART: I've got a few questions around a couple of subjects. Can you tell me what actions AHPRA has taken to ensure patient safety is a priority for cosmetic procedures? We've all seen a lot of stories about disastrous outcomes. Can you tell me what actions you've taken to ensure the safety of patients?

Mr Fletcher: Like you, we were deeply concerned about a number of media reports some 12 months ago in relation to patients being harmed by cosmetic surgery. I also want to acknowledge the bravery of the people who came forward to speak about their experience. In the wake of that media reporting we commissioned an independent review led by Mr Andrew Brown, the former Health Ombudsman from Queensland. That review reported and was published in full on 1 September this year. It made 16 recommendations to both AHPRA and the Medical Board of Australia for actions that we should take to address these patient safety issues in the cosmetic surgery industry. We've accepted all of those recommendations, and we're also very pleased to get strong support from health ministers across Australia for that response as well.

Senator URQUHART: Can you tell me what the time line of the implementation of those recommendations is?

Mr Fletcher: Essentially, what we've done is establish within AHPRA a cosmetic surgery enforcement unit, and we've put $4.5 million of our resourcing into that unit. Essentially what that is doing is really now spearheading all of our work in relation to the response to the recommendations. For example, we've established a cosmetic surgery hotline and are doing a lot of promotion with the community to make sure that people are telling us about their bad experiences. One of the features of the industry is that bad things were happening and they weren't necessarily being raised with us. There is work under way on strengthening the guidelines around things like advertising, the expectations of medical practitioners, and they'll be going to public consultation this month, with the expectation that they'll be finalised early next year. We've written to every doctor already in Australia—133,000 medical practitioners—reminding them of their obligations in relation to reporting any unsafe care that they see, so that we can look at whether we need to take action. Then there's also work under way through the Medical Board of Australia and the Australian Medical Council to develop an area of practice endorsement. Essentially what that will do is set a minimum standard in relation to training and qualifications, which would allow a medical petitioner doing cosmetic surgery to actually apply for and meet those requirements. That would then be on the public register. That would help the public in terms of knowing people have met certain minimum requirements. Again, that will ultimately need to be something approved by all health ministers in Australia through the Medical Board of Australia. We expect to have that finalised for ministers' consideration early next year.

Senator URQUHART: That is great. There has been criticism of the pace of response by AHPRA. I think you've covered off on a lot of that and hopefully that pace is now ramped up with all those things you've just

talked about. Very quickly, because I'm conscious of time, can you tell me what's the annual budget of AHPRA? If it's easier to take this on notice, I'm happy for you do that.

Mr Fletcher: I'll quote from our 2021 audited financial statements in our annual report, which will be tabled in the parliament. Our expenditure in 2021 was $232 million.

Senator URQUHART: How many staff does it employ?

Mr Fletcher: Our total FTE staff is 1,163.

Senator URQUHART: How many of those would be classified as senior staff?

Mr Fletcher: I'd have to take that on notice.

Senator URQUHART: How many are currently dedicated to compliance activities?

Mr Fletcher: When you say 'compliance', what do you mean?

Senator URQUHART: In terms of looking at how the medical profession are dealing with the issues that you're responsible for?

Mr Fletcher: If we look at, say, our work on notifications compliance, our legal services, our frontline customer service response to queries, our registration work—and I should make the point that this is across 16 regulated professions—about 67 per cent of our staff are involved in that work.

Senator URQUHART: What is AHPRA doing to tackle the barriers in relation to migration? What role do the colleges play, such as the royal college of general practice, to assist with migration? How could they assist to improve the process? I'm talking obviously about GPs and other specialists coming from overseas.

Mr Fletcher: Are you talking about our work in relation to registration of health practitioners, essentially?

Senator URQUHART: Yes.

Mr Fletcher: I will turn to the right page in my brief so I can give you the accurate numbers.

Senator URQUHART: I don't want just raw numbers. I also want to know what things you're doing to tackle the barriers that are there in relation to people migrating.

Prof. Murphy: While Mr Fletcher is finding his page, we should point out that the barriers are much broader than just AHPRA.

Senator URQUHART: I understand that.

Prof. Murphy: We have a taskforce under the direction of health ministers working on all of those barriers, visas, the like. But AHPRA—

Senator URQUHART: I understand that. I'm interested in what AHPRA's role is in that.

Mr Fletcher: Our particular role is in relation to the registration of health practitioners who are seeking to practise in Australia. When we are registering, it's more than just an administrative process. We firstly have to make sure that the qualification they have is equivalent to a qualification that an Australian trained graduate from an approved program of study would have. Secondly, we need to make sure that they meet the required standards of each of the 15 national boards. English language would be an example there. Thirdly, we need to make sure they're suitable for registration in Australia. We would look at things like criminal history. We would look at whether there were any outstanding regulatory issues in the country from which they're coming to Australia. That's what's involved in the registration process. In relation to the role of colleges, particularly as it relates to international medical graduates seeking specialist work in Australia, they have a role in assessing the equivalence of the qualification. Depending on their finding there may be additional requirements placed on somebody to make up the gap between what the qualification they have is and what the equivalent would be in Australia. As I say, once that's done and they come to us for registration, we are checking those requirements, confirming the qualification, confirming they meet the standards and also confirming their suitability for registration.

Senator URQUHART: Do you think there's anything more that AHPRA could do in terms of assisting that process in the time frame?

Mr Fletcher: For example, we have recently increased our staffing substantially in that international registration area, particularly around not only IMGs, international medical graduates, but also internationally qualified nurses, recognising the workforce pressures there are. Secondly, one of the things that we often find delays the registration process is if we get an incomplete application and we have to go backwards and forwards to get all the information we need. We've now turned all of our processes around and put our most senior staff at the front end of the process so that an applicant finds out very quickly if there's more information we need rather than having to wait and then discover a few weeks later that there's information that we don't have that we need.

We've also done quite a lot of work with employers particularly around IMGs, to make sure, because they're often supporting IMGs coming into positions in health services in Australia, they're very clear on what the requirements are and that they've got all the information they need. More widely, particularly as it relates to general practice, we're about to set up a joint working group with the RACGP looking at just how the interface of what they do around the assessment of qualifications and what we do around registration can be smoother. I'll give you the example that sometimes there's information we need, there's information the college needs and it's the same, and so is there a way we could share that information safely? Can we make sure the information we're providing to people who are wanting to come to Australia is clear, aligned, easy to read and easy to find? We're also just looking at some of the coordination issues there are at times. We're certainly looking actively to work to reduce any of those sources of preventable delay in relation to the registration of international—

Senator URQUHART: I wanted to clarify one thing. The additional staff that you've put on are in that 1,113 that you talked about?

Mr Fletcher: That's correct.

Senator URQUHART: That's great.

Prof. Murphy: I'll make one clarification. First ministers have commissioned an independent review of all of those regulatory settings for overseas trained practitioners to provide an independent view of whether there's anything else that could be done to speed up the regulatory process. That will be happening over coming months.

CHAIR: I'll pass the call around.

Senator ANTIC: The complaint I hear from doctors routinely is that AHPRA has now fundamentally damaged the doctor-patient relationship by centralising control of COVID management with the so-called position statement on COVID, the 9 March statement. Firstly, why did AHPRA see fit to do this now for COVID when it has never done it before? I want to ask you some further questions about that position statement as well.

Mr Fletcher: I want to start my comments by acknowledging the extraordinary work that registered health practitioners have done across Australia in relation to the COVID-19 pandemic. We are very keen to support that work in any way we can. The joint position statement that was issued in March 2021 was actually issued by AHPRA and all of the 15 national boards collectively. It's not just a view from AHPRA, it represents the view of the boards for all of the regulated health professions in Australia. It was a response to queries that we were receiving about practitioner obligations in relation to COVID-19 vaccination, and that was at a time when a number of jurisdictions were also putting in place requirements around mandatory vaccination. The statement essentially aims to make clear how national boards are applying existing regulatory frameworks in the context of COVID-19. I think it's important to emphasise that the obligations in that statement were not new obligations. They are obligations that are entirely consistent with the code of conduct for each of the 15 national boards, and they obviously predate the pandemic. At the core of that was an expectation, as it has always been, that health practitioners would use both their professional judgement and the best available evidence in practice, and that includes providing information to patients and the public on things like social media.

Senator ANTIC: Can I just stop you there. That's not how it rolled out in practice, though, was it? Many doctors tried to use their professional judgement with respect to concerns raised about the vaccines and their safety and efficacy, which we now know is a nonsense, and in so doing incurred the ire and the wrath of the regulator. Many have been deregistered for doing so. My question to you is: do you accept that position statement has disfranchised large elements of the medical profession and forever damaged the doctor-patient relationship?

Mr Fletcher: It's important to separate—

Senator ANTIC: That's a question.

CHAIR: Apologies for interrupting. Senator Antic, are you willing to table the media release you're referring to?

Senator ANTIC: It's a position statement. It's on the website.

CHAIR: Are you happy for that to be tabled?

Senator ANTIC: Yes; it's their position statement.

CHAIR: I've just had a request for the document to be tabled.

Senator ANTIC: I don't have it with me.

Prof. Murphy: We could arrange for that.

CHAIR: Thank you. Please proceed.

Senator ANTIC: The question was: has the doctor-patient relationship been fundamentally damaged?

Mr Fletcher: What I think is important to clarify here is these extraordinary claims that AHPRA is actually deregistering or threatening to deregister doctors and other health practitioners who raise concerns about COVID-19. I welcome this opportunity to set the record straight. I think the first thing to say is that in fact AHPRA and national boards have no powers to deregister, under national law, or cancel the registration of any health practitioner. That is the decision of an independent state or territory tribunal or a court. It's only the case in very serious matters, and each case is decided on its own merits. I can tell you today, to date, no health practitioner has had their registration cancelled in a tribunal in the jurisdictions in which we have responsibility for because of the views they've expressed about COVID-19.

Senator ANTIC: How many doctors, medical professionals and allied healthcare professionals have been investigated during this period by AHPRA?

Mr Fletcher: Let me give you the facts and figures for 2021-22 for COVID-19 notifications. It's probably worth reminding you that we do not deal with notifications in New South Wales. They are dealt with in a separate system, and we only deal with those notifications in Queensland that are referred to us by the Office of the Health Ombudsman. Noting that, we dealt with, or we received, 1,303 notifications about the conduct or health or performance of a registered health practitioner relating to COVID-19 during 2021-22. That related to 1,006 practitioners and they were across the professions of medicine, nursing, chiropractic, dental, pharmacy, paramedicine and psychology. That represented about 12 per cent of all the notifications we received in 2021-22. We dealt with about 10,800 notifications in that year. If I just give you an idea of the flow, between September to December 2021 that averaged about 36 per week. By June 2022 it was about five per week.

Senator ANTIC: So, this is a broader question, then. It is very clear that medical professionals, healthcare professionals and others have not been in a position to express their professional judgement with respect to some of these issues. Many have balked at the vaccine rollout, for good reason, in my view. Whether it be at the hands of the regulatory body or AHPRA, is it the position of AHPRA that there needs to be an amendment to the legislation to enable further freedom to doctors to prescribe in accordance with their own treating practices?

Mr Fletcher: We are not seeking any amendment to the legislation.

Senator ANTIC: So, you are quite comfortable with doctors being silenced on this issue?

Mr Fletcher: I don't believe we are silencing doctors. If I could perhaps just finish my answer and explain the type of concerns that we deal with, just to give you a flavour. Firstly, we've had concerns in relation to clinical care, which is typically related to things like vaccine exemptions that have not appropriately followed the ATAGI guidelines. We've had concerns from patients about not being able to access care, because health practitioners have refused to treat them because of concerns about COVID-19. We've had concerns expressed to us about the behaviour or conduct of health practitioners. For example, refusals to wear masks, not complying with public health directions or lockdown requirements. We've had concerns about people practising while they were unwell, and poor infection control, and we've also had concerns about the online conduct of health practitioners, for example, propagating what might be termed conspiracy theories.

Senator ANTIC: I want to stop you there. The position statement says that national boards expect health practitioners and students to provide accurate information and advice regarding COVID-19 vaccination. Who exactly determines what accurate advice is?

Mr Fletcher: Our reference point in relation to the accuracy of advice would be the public health guidance that was in place within each of the states and territories and the Commonwealth. If we were looking at issues around vaccines exemptions, we would look to the advice from ATAGI and we would also look to TGA as our major sources of advice.

Senator ANTIC: So, in effect, this is a great big bureaucratic stitch-up over the top of medical practitioners? It's a cartel, if you will, of regulatory totalitarianism? Is that how you'd describe it?

Mr Fletcher: I wouldn't describe it like that, no.

Prof. Murphy: It's a regulatory environment that works on the basis of the best available evidence.

Senator ANTIC: But the chain of command ultimately has been stifling medical practitioners?

Mr Fletcher: I don't accept that characterisation. I don't believe the data bears out what you're saying.

Senator ANTIC: What exactly constitutes an antivaccination statement?

Mr Fletcher: What we would look at is the guidance that is in place at the time, so when the statement was being made, and decide whether there was any issue with the consistency, as I say, with those authoritative sources that we would look to in terms of jurisdictions, TGA and ATAGI.

Senator ANTIC: You just do what the guys up the tree tell you to do; is that right?

Mr Fletcher: Sorry?

Senator ANTIC: You just do what the bureaucrats up the tree do?

Mr Fletcher: No.

Senator ANTIC: Follow suit like a conga line?

Mr Fletcher: I think it's also important to note that it is not AHPRA making the regulatory decisions about these practitioners. We have boards for each of the 16 regulated professions. There are 15 national boards. They are comprised of practitioner members and community members. If needed, particularly if we were going to a tribunal with a matter, we would also probably seek expert opinion from a practitioner who is from within the profession of the practitioner that we're concerned about.

Senator ANTIC: Why is it, therefore, that AHPRA and indeed all of the bureaucratic conga line do not trust healthcare workers enough to provide advice for their patients who they see every day in conjunction with their own medical expertise?

Mr Fletcher: I don't believe that's the case. We do trust our health practitioners. The guidance that we issue, as I say, is entirely consistent with the code of conduct and is designed to make clear the obligations and expectations for our practitioners.

Senator ANTIC: I think the whole system needs an overhaul. That's what I think.

CHAIR: Senator Rennick.

Senator RENNICK: Could I get the numbers, if it's possible for you to provide this on notice, of doctors, nurses, ambulance drivers and paramedics that have been registered from 2019, 2020, 2021 and 2022, just to get the last four years? I will pick up on that position statement. I notice Professor Murphy said the 'best available evidence', and that's a good point. The FDA in December actually stated that Pfizer said that data was not available to make a determination about how long the vaccine would provide protection, and nor is there evidence that the vaccine prevents transmission from person to person. ATAGI has come out in updates from September to December 2021 and stated that vaccination was an intervention to prevent infection transmission. So, ATAGI has contradicted what the FDA has said about transmission. That is a good example of how the so-called experts, many of whom work for universities that receive significant funding from big pharma as well as the likes of the Bill and Melinda Gates Foundation, which is heavily invested in vaccines, didn't get the data right. Why should we trust the regulatory experts over the expertise of individual doctors, nurses and paramedics who, quite rightly, have raised the risks? I've just spoken about this with the ACCC and ASEMA. Why are they being suspended? You're being clever with words when you say no-one has been sacked. Plenty of people have been suspended and there is a culture of fear amongst doctors and nurses.

CHAIR: Could senators at the table allow Senator Rennick to ask his question. It's a bit hard to follow.

Senator RENNICK: My question is: what have you got to when ATAGI gets it wrong, and they've clearly got it wrong with regard to transmission?

Prof. Murphy: I don't think that's an appropriate question for the CEO of AHPRA, about the veracity of ATAGI's advice.

Senator RENNICK: That's the advice they rely on.

Prof. Murphy: Yes, we are very happy to defend ATAGI's advice and the evidence upon which it's based. But I don't think that's a question for the CEO of AHPRA.

Senator RENNICK: So, now you're running interference.

Prof. Murphy: No, I'm not running interference. You can ask questions about regulation, but I don't think you can ask questions—

Senator RENNICK: Can you not interrupt? The question isn't to you. The question is to you, Mr Fletcher. There is a culture of fear, because a lot of doctors who have much more expertise than many of the so-called experts on the ATAGI board, have knowledge about the risks of mRNA, and so on, have been shut down, suspended or threatened with suspension. Why will you not take their advice or let them use their own discretion based on their significant expertise as opposed to those in ATAGI, who don't have the same level of advice?

Mr Fletcher: Again, I think it's important that we sort the fact from the fiction here. Let me go back to the data in relation to the notifications that we've dealt with. If I can complete my answer to the previous question—in fact, of those 1,300 notifications we received, around 50 per cent of those—this is at June this year—had resulted in no further regulatory action. In other words, we'd looked at the matter, assessed it and decided there was nothing that we needed to do as a regulator. You're right to say there are practitioners that we have suspended

from practice. There are 28 practitioners whom we have suspended from practice in relation to COVID related matters. It's important to note, first of all, that suspension is an interim measure whilst we undertake an investigation. We can only do it where there is a significant concern about public or patient safety or a public interest issue that requires us to take that action while we look further at the concerns being raised with us. If I can just give you the flavour of those—11 of those suspensions were in relation to conduct related to spread of what you might consider COVID misinformation, for example, claims that COVID-19 was fake, that vaccine programs were government-led mind control, just to give you an example. Ten were suspended because of their failure to comply with public health orders, serious or at times fraudulent behaviour. So, fake vaccination administration certificates or fake exemptions. Sorry. I should say that's 28 practitioners subject to immediate action; 21 suspended, 11 and 10; and then seven are subject to restrictions or conditions such as supervision or limitations in relation to their vaccination exemption or prescribing. Can I just make the point that there are 830,000 registered health practitioners in Australia. The vast majority are doing the right thing.

Senator RENNICK: Have you employed staff to look at doctors who have been writing exemptions for adverse events—and think very carefully about this statement—to actually then red-flag doctors who have been writing exemptions for the vaccine?

Mr Fletcher: Because of the number of notifications that we received about COVID-19, we set up a special COVID task force within our existing staff, and we also worked particularly with the Medical Board of Australia to have a special committee that dealt with all of the COVID notifications in relation to medical practitioners.

Senator RENNICK: So, you were red-flagging doctors who were writing?

Mr Fletcher: No, we're not red-flagging. That was in response to the notifications we were receiving. We were not out there doing surveillance, if that's what you're asking. We were responding to the notifications we were receiving.

Senator RENNICK: That's not what an AHPRA employee told me. I will finish on this. I have been told by numerous doctors of numerous people with vaccine injuries that have gone back to get an exemption and been forced into getting a second shot to keep their job. They have gone back to try to get an exemption, and the doctor will not write it. They are afraid to write exemptions for people who are injured by the vaccine. I know Professor Murphy didn't believe me last time when I said that. I put up a post. I got seven a half thousand people who were sacked because they wouldn't get the second shot. Of that, 407 were both injured and sacked. That's the culture of fear that is out there. You are going to have to live with that. It is a shocking indictment that we are living in a country where people are being forced to get injured—

CHAIR: Senator Rennick, can I ask you to direct this as a question.

Senator RENNICK: My question is: why have we got doctors out there who are afraid to write exemptions for people who have been injured by the vaccine?

Mr Fletcher: Obviously we do not want doctors to be fearful of AHPRA and the regulatory scheme. We are here to support professional practice. But I don't step back from the fact that our fundamental focus is on public safety and patient safety. If concerns are raised with us about risks to public and patient safety, we are obliged to look at those concerns—the law requires us to look at them—and if there's a need for us to take regulatory action we will take it. In the majority of notifications we deal with across-the-board we don't to take regulatory action, but we don't step back from needing to do so where there is that risk to public safety.

Senator RENNICK: So, you will defend the right of doctors to apply their own discretion to people who have been injured by the vaccine?

Mr Fletcher: We defend the right of doctors to use their professional judgement and the best available evidence. As I've said earlier, in our view, the best available evidence is that is provided by public health experts in each of the jurisdictions, ATAGI and TGA. And where needed, at the more serious end of concerns being raised, we would also seek expert opinion.

Senator RENNICK: But evidence in a trial doesn't outweigh a diagnosis of an individual. It's the dignity and worth of every individual that matters. I have a son who is allergic to penicillin. I know it's a commonly used drug. It's safe in most cases. Everyone has different allergies. Are you saying that the public evidence based on a trial is going to outweigh an individual doctor's diagnosis of a patient?

Mr Fletcher: I'm saying that we refer to those sources of expertise if we have concerns raised, but we look at the merits of the individual case. This is not a one-size-fits-all cookie-cutter.

Senator RENNICK: Exactly; that's my point.

Mr Fletcher: We look at individual circumstances, and that will determine whether we came to a view that there was a public safety risk that needed regulatory action.

Senator RENNICK: Thank you. That's all I needed to know.

CHAIR: Senator Ruston.

Senator RUSTON: Mr Fletcher, I'm interested to understand the structure of AHPRA. Could you explain to me how your board is constituted?

Mr Fletcher: There are in fact 16 boards within the national registration and accreditation scheme. So, 15 of those boards are for each of the regulated health professions. The reason there are more professions than boards is that, although nursing and midwifery are considered to be two separate professions, they're regulated by one board, the Nursing and Midwifery Board of Australia. Each of those boards comprises two-thirds practitioner members and one-third community members. All of the vacancies on those boards are advertised, and we have three-year terms. The decision about appointments to those national boards are made by the Health Ministerial Council, which is all of the state and territory health ministers and the Commonwealth health minister. Most people can have up to three terms. The other board is the AHPRA board, which is the corporate board of AHPRA. The people on that board are also appointed by the Health Ministerial Council, also for three-year terms, up to usually three-year terms, and also advertised when vacancies arise. They essentially are the corporate board of directors for AHPRA. Our role is to administer the national registration scheme. Essentially each of the national boards then sets the relevant policy and standards, and regulatory decision-making frameworks for each of the 16 registered professions.

Senator RUSTON: I'll unpack that a bit. We have 16 boards, and 15 of them, I'm assuming are largely reflective of the wants of the colleges that represent the specialties, plus nursing. Have you got a list of the 15?

Mr Fletcher: Yes, we can provide you with a list of the boards and the membership.

Senator RUSTON: It could well be on your website. I had a look at it, but it seemed to be more of a glossy document than anything else.

Mr Fletcher: We can certainly provide that.

Senator RUSTON: In relation to the AHPRA board itself, how is that constituted? Where do you get your board from?

Mr Fletcher: The national law says that there must be a minimum of five members of the AHPRA board, and there's particular expertise, such as around education and administration and business. Those vacancies are advertised, and there are three-year terms.

Senator RUSTON: Who appoints them?

Mr Fletcher: The Health Ministerial Council, state and territory health ministers and the Commonwealth health minister.

Senator RUSTON: So, do each of the 15 boards provide advice as to who their representative should be on the main board? I'm trying to understand how AHPRA actually works and where the chain of responsibility and the chain of authority goes. Every time I try and dig into this I end up at a dead end, and I'm not really quite sure who's responsible for what. We've got AHPRA as the national health regulator, and AHPRA has a board that's made up of these 16 boards. Surely you don't have 16 boards turn up every time you have a meeting?

Mr Fletcher: No, they are quite separate entities. The 15 national boards essentially set the regulatory policy and standards in relation to the professions that they are responsible for. They also set the framework for regulatory decision-making.

Senator RUSTON: If you've got an issue in relation to an area in health that is not necessarily the jurisdiction of one of the boards that you work with, how would you seek to resolve that? Would that go to the AHPRA board?

Mr Fletcher: It would depend on the issue. For example, we do a lot of work on multiprofessional policies. The statement that's been referred to, as I said, was actually a statement from all of the boards. It might be an issue where we actually seek to have a common position across all of the boards in relation to a policy piece or piece of guidance or the like. Let's take, for example, the discussion that we've already had about workforce. That might be a more specific discussion with, say, the Medical Board or the Nursing and Midwifery Board, given the focus on those professions in relation to, say, for example, internationally trained practitioners coming into Australia. AHPRA essentially administers the scheme on behalf of the boards. The boards delegate to AHPRA certain powers, but AHPRA also has some specific governance responsibilities in relation to the scheme. I can follow up with some information that explains how it all works, because there are quite a lot of moving parts.

Senator RUSTON: Just going to the AHPRA board; you are a creation of the states and territories and the Commonwealth?

Mr Fletcher: We're a creation of the states and territories. We are a national law model. Our legislation is state and territory legislation, not Commonwealth legislation.

Senator RUSTON: Yet you seek to regulate jurisdictionally much that is financed by the Commonwealth?

Mr Fletcher: The scheme is self-funded by the registration fees.

Senator RUSTON: No. You're regulating the health sector. We all know that the health sector sits in various jurisdictions, and a significant amount of the funding that goes into the health sector sits within the Commonwealth. Is there another body that regulates on behalf of the Commonwealth or does the entire regulation sit only with AHPRA?

Mr Fletcher: We regulate registered health practitioners. We register health practitioners across Australia. In terms of regulation, where we're dealing with what we'd call a notification, we deal with those in all jurisdictions except for New South Wales, where they're dealt with through a separate system. In Queensland we do that in conjunction with the Health Ombudsman in Queensland. There are some matters that she deals with, there are some matters that we deal with and we agree that as those matters come to our attention.

Senator RUSTON: Going back to the board, you said within your guidelines or your requirements; I'm assuming you are formed under the legislation that sits under national law? What is the statutory structure of AHPRA?

Mr Fletcher: Essentially, when the scheme was created ministers agreed the legislation. It was then passed in the Queensland parliament, as the host parliament, and is essentially adopted in every other jurisdiction, although in New South Wales and South Australia they need to pass a regulation. In Western Australia there is not mirror legislation, and so they have to do corresponding legislation. For example, there has just been a package of amendments to the national law passed in the Queensland parliament, and Western Australia will need to introduce their own legislation to pick up those amendments.

Senator RUSTON: Yes, and we'll go to those in a minute. Just talking about the structure and the set-up of AHPRA, the requirements in relation to your statutory existence are basically embedded in a piece of legislation that has gone into the Queensland parliament and then been adopted by the various jurisdictions by whatever mechanism they need to adopt it. The constituency of your board is determined by that legislation?

Mr Fletcher: Of the AHPRA board?

Senator RUSTON: Yes.

Mr Fletcher: It sets requirements around the expertise that needs to be on the AHPRA board.

Senator RUSTON: And then who makes the determination as to who those people are?

Mr Fletcher: Health ministers, the Health Ministerial Council; all health ministers have to agree.

Prof. Murphy: Including the Commonwealth health minister.

Senator RUSTON: What is the process that's normally undertaken in relation to that?

Mr Fletcher: Any vacancies are advertised extensively. The then health chief executives of jurisdictions on behalf of health ministers agree a selection panel that reviews those applications. We provide support for that process, administrative support, and then a recommendation ultimately would go through health chief executives to health ministers about either new appointments or reappointments.

Senator RUSTON: Do the other 15 boards have any involvement in that process or is it entirely a bureaucratic process?

Mr Fletcher: No. It's essentially a government-led process that AHPRA administers.

Senator RUSTON: Can you provide us with a list of your current board members and their terms and when they expire?

Mr Fletcher: For the AHPRA board?

Senator RUSTON: Yes.

Mr Fletcher: That would be great.

Senator RUSTON: Is it normal practice that the Health Ministers Council accept the recommendations of that panel or have there been occasions when health ministers haven't accepted the recommendations of the panel?

Mr Fletcher: When you say 'panel', what do you—

Senator RUSTON: Obviously there's a recommendation that goes up through the bureaucrats to the ministers.

Mr Fletcher: I see; about appointments? I'm not aware that there has been a recommendation that's not been accepted, but I'd probably have to double-check that.

Senator RUSTON: In advice to Senator Urquhart you said that your annual budget is $202 million. Did I hear that correctly?

Mr Fletcher: Let me just go back and make sure I give you the right number. Our expenditure last year was $232 million.

Senator RUSTON: So, $232 million?

Mr Fletcher: Yes.

Senator RUSTON: Do you have a breakdown of how that revenue comes about? How do you generate that revenue?

Mr Fletcher: That revenue is predominantly generated by the renewal fees that registered health practitioners have to pay. You have to renew your registration on an annual basis, confirm you meet the standards, and there's a fee associated with that renewal. It's different for each profession. One of the design principles of the scheme agreed by ministers when it was established is that each profession essentially needs to pay their own way. We seek to minimise any cross-subsidisation between professions for the costs of regulation.

Senator RUSTON: Of the $232 million that you generated in fees, how much of that was expended in activities that were undertaken by AHPRA?

Mr Fletcher: The $232 million was our expenditure.

Senator RUSTON: That was your expenditure?

Mr Fletcher: Our income for the year was $249.7 million.

Senator RUSTON: What happens to your excess funding?

Mr Fletcher: Each of the national boards carries an equity reserve. Depending on which profession it related to, it would go back to that equity reserve. That equity reserve is used for things like significant capital investments. For example, after 12 years we're upgrading all of our IT systems so we would draw on that equity for that purpose. It also goes to uninsurable catastrophic risks, if you like, which may be around practitioner matters. Obviously, in the current environment cybersecurity would be an example of something there potentially.

Senator RUSTON: Who makes those decisions? Do you have the delegated authority as the chief executive to make decisions about expenditure? I'm assuming that you put forward an annual budget—

Mr Fletcher: That's correct.

Senator RUSTON: including a corporate plan to the health ministers and they sign off, and that part of it is just a standardised practice?

Mr Fletcher: We don't put it to health ministers. We put an annual budget and our strategic plan and our business plan to our AHPRA board each year, and that's agreed through their corporate governance responsibilities. Part of that process, though, is that there is extensive consultation with each of the national boards in the development, because we also need to develop the budgets for each of those national boards; there may well be initiatives that they are taking forward that are profession specific that need to be funded, as well as the costs of running AHPRA.

CHAIR: Do you have many more questions for AHPRA?

Senator RUSTON: I have a lot more questions.

CHAIR: Are there any that you're able put on notice so we can move to the rest? Can you give me an indication, please, of how much—

Senator RUSTON: I probably have another three-quarters of an hour.

CHAIR: We have a number of senators in the room and a number of agencies.

Senator RUSTON: I'm happy to cede to other senators.

CHAIR: I was hoping to deal with this agency. If we have to spend another 45 minutes here, we won't get to outcome 1 or the other agencies.

Senator RUSTON: I'm just delighted that we've got AHPRA here. They don't normally come, and I thank you very much for being here. I'm fascinated by what you do, as you can see.

CHAIR: We might move to one of the other agencies now. We'll return to AHPRA shortly. I just want to give some other senators in the room the opportunity to ask some questions, and we will come back to you, Senator Ruston. We will work through in order of the small agencies. My hope is to dismiss as many as we can. We'll move to the Australian Institute of Health and Welfare.

Australian Institute of Health and Welfare

[09:59]

Senator STEELE-JOHN: I want to kick off by asking how many people in Australia are on waiting lists for general dental care, denture care and assessment of dental services?

Mr Heferen: We don't have the detail of that question available. If we could take that on notice, we'll provide an answer, to the extent that we have that data.

Senator STEELE-JOHN: Yes.

Mr Heferen: There's also a question of the data that we have available. It may be that we have information along those lines. We do some reporting on dental. In Australia's Health, we update that as one of our biennial reports. I can't recall off the top of my head what level of detail we can go to on dental. We can take that on notice and come back to the committee.

Senator STEELE-JOHN: Yes. In terms of the information that you might have, either in mind or to hand now, do you have a picture of what the national waitlist looks like? Do you gather that information, or is that not something that you do?

Mr James: I'll give you an example. We don't have waitlists, for example, on mental health; so we don't have a waitlist, for example, of people waiting to see psychiatrists or psychologists. We do things like waiting times for elective surgery in hospitals and things like that, but often we don't have waiting times for particular medical professions. Often that data is not centrally collated.

Mr Heferen: Certainly, with waiting times for dental—that's the one in particular—I'm fairly sure that we don't. Before I'd say a definite 'no', I'd like to take that on notice, just to make sure that is correct.

Senator STEELE-JOHN: Regarding what Mr James has just said, in terms of the elective surgery—the surgery wait times that you have—do you break them down so that we might at least be able to identify the dental surgeries captured within that number?

Mr James: We certainly cross-classify that data, and that's available by different types of things that people are waiting for. I don't have that detail in front of me, but we could get that to you.

Senator STEELE-JOHN: Okay. For good reason, you're a well-respected organisation in the community; people, I think, trust the information that you provide. I know that you're going to take it on notice but, if the answer is no, what would it take for you to be able to gather this data?

Mr Heferen: The data we gather is typically data that, largely, through the governance arrangements of the health ministers and the health chief executives forum—they would say, 'It's important to have information on this particular area.' Typically, it would be the states and territories that would provide us with information. In doing that—

Senator STEELE-JOHN: What forum was that?

Mr Heferen: The health ministers.

Senator STEELE-JOHN: They would give you a directive—

Mr Heferen: Yes. The way it normally goes is that the health agreements are signed up and, in those health agreements, there will be schedules about: 'Here is information and data that ought to be provided to, in this case, the Australian Institute of Health and Welfare.' When that happens, we would work with our state and territory colleagues to work on a consistent way of reporting so that, when we do report, it's on a nationally consistent basis. That's the general model; then, say, in the hospital environment. When it comes to ones where there's not only a public element but also a large private element—say, with dental—it's then much more challenging. With the public hospitals and, indeed, the private hospitals, we can get good data. They're large organisations and, typically, are pretty sophisticated, as far as their data requirements go and data capability, so that's feasible.

Senator STEELE-JOHN: It would be complicated, but—

Mr Heferen: Sorry, could I continue? The idea of the institute, of its own volition, going out and deciding to get information: when we do that—and, typically, because we're governed by our board, if the board is keen for us to step into a particular area, what we would typically do is tap into reporting sources that are already there.

We have no capacity to compel; so, with reporting sources that are already there, we'd bring material together and report in such a way that hopefully brings a synthesis and an analysis to that.

Senator STEELE-JOHN: The first step to getting that information would be a directive or recommendation to come out of that ministerial meeting between the states and territories and the Commonwealth health minister.

Mr Heferen: Certainly, if there was some direction for us—and, of course, I'm not suggesting—

Senator STEELE-JOHN: No; I'm just trying to understand.

Mr Heferen: But, if there was a direction for the board to instruct us to do that, we would endeavour to do whatever we were instructed to do.

Senator STEELE-JOHN: You'd endeavour to take it on. When is the next one of those meetings?

Mr Heferen: I'm not aware.

Senator STEELE-JOHN: That might be a question for—

Prof. Murphy: The health ministers are meeting next week. They're meeting every month. Minister Butler is driving a strong agenda for health ministers meetings.

Senator STEELE-JOHN: Finally, I ask the minister representing the health minister: do you know whether the minister has indicated a willingness to put such an item on the agenda for a subsequent meeting of state and territory health ministers, so that the institute would undertake that work?

Senator McCarthy: I'm not aware at the moment, but I can certainly take that on notice. Obviously, that would be a discussion with the minister, and I'm more than happy to have that conversation and get back to you.

Senator STEELE-JOHN: All right. Could you take on notice for me, Mr Heferen—just in case there is information hanging around, although it seems that there isn't—whether you have information about the number of people who are on waiting lists for general dental care, denture care and the assessment of dental services in Australia. Additionally, if you have that information, could you indicate how many are under the age of 18, how many are over the age of 65 and what the average time on the waitlist is?

Prof. Murphy: Can I clarify something. I think what you're getting at are the public dental waiting lists. I think Mr Heferen is saying that to go into the private dentists is almost impossible.

Senator STEELE-JOHN: Yes. Literally, I'm seeking any information that you can give me on dental care in Australia of any type; yes, for public, if that's what you've got.

Mr Heferen: We'll take that on notice and endeavour to provide you with what we can.

Mr James: There is some relevant information in the ABS patient experience survey. That gives you data on whether people faced cost as a reason for not seeing a dentist, for example. That's published by the ABS; I've got that in front of me.

Senator STEELE-JOHN: Public is great.

Mr Heferen: We'll make sure that we include that in the information that we'll provide to the committee.

CHAIR: Senator Steele-John, I understand that you're seeking to share your block with Senator Waters?

Senator STEELE-JOHN: Yes.

Senator WATERS: Thank you very much, to both Senator Steele-John and the chair. Can I ask about maternity care, please? The latest AIHW maternity models of care data show that only 31 per cent of pregnant people are able to access continuity of care through their pregnancy. Can I interrogate that 31 per cent figure? I presume that's a national figure and that access to continuity of care would be much lower in certain areas. Could you let me know if you have any regional breakdowns of that figure?

Mr Heferen: I'm afraid that you've landed on one that is outside our immediate area of expertise. We do produce a lot of reports a year, so apologies if we don't get—

Senator WATERS: They're very good. Do you have the relevant officer perhaps to hand?

Mr James: Not here today.

Senator WATERS: Not here, okay.

Mr Heferen: If there's something general—when was that report that you mentioned?

Senator WATERS: That is an excellent question. I don't know. You tell me; it's your report. I don't have the date here, I'm sorry. I've got the link to it, but I haven't printed it. If you need to take it on notice, that's fine.

Mr Heferen: Yes, we'll take it on notice.

Senator WATERS: I'm also interested in—I'm not sure if this is a question for you or for the department—whether you have figures on how many public hospitals offer birthing centres and midwife-supported birth models.

Mr Heferen: Yes, we will have that information—

Senator WATERS: Take that on notice also.

Mr Heferen: I'll also take that on notice.

Senator WATERS: Thank you. This one definitely is for the department: what is the department or the government doing to increase access to continuity of care models across the public system?

Prof. Murphy: I might see whether Professor McMillan, who is doing our work on midwifery, is here. Yes, Professor McMillan is coming to the table. It is a very important issue for government.

Senator WATERS: I'm pleased to hear it.

Prof. McMillan: The access to continuity of care, as you know, is based on how maternity services are provided predominantly through the jurisdictions. All of the states and territories and the Commonwealth committed to a woman-centred care program of work that commenced in 2018. As a part of that, there is a commitment to further advancing access to continuity of care models, but the responsibility for the delivery of these services predominantly lies with the jurisdictions that run the public hospital system.

Senator WATERS: I have written here that it was a strategy that was released in 2019, but 2018 is close enough. That's several years ago. I hear that you are wanting to enhance access, but what actions have been taken to do that by the federal level of government?

Prof. McMillan: Again, the action to address and increase access to continuity of care does lie with the jurisdictions. We have recently re-established a senior officials group that is looking at all of the elements and recommendations of the woman-centred care strategy and looking at the progress they've made in relation to a number of those actions required. At the moment we're working with all of the jurisdictions to look at a monitoring framework that will tell us better the progress of those. Again, ultimately, it is the jurisdictions that need to do the work predominantly in the maternity hospitals to expand that access.

Senator WATERS: I'll come back to that point. On that monitoring and evaluation framework, when will that be finalised?

Prof. McMillan: As for when we're aiming to complete that, it's probably best to take that on notice, so that I have it accurately.

Senator WATERS: Sure. Will consumers be involved in co-designing that monitoring and evaluation framework?

Prof. McMillan: Again, I will need to take that on notice, just to check the consultation process on that monitoring and evaluation framework.

Senator WATERS: Okay. I want to push back a little on your contention that the continuity of care is primarily a state and territory responsibility. Given the role that MBS and PBS, for that matter, could play—I'm not sure who this is relevant for—can you tell me about any advancements in listing MBS items? I attempted to ask this the other day; it might have been you that I spoke with, Professor McMillan, over the video link.

Prof. McMillan: Yes, it was.

Senator WATERS: Perhaps you can expand on what you told me then, because I still don't have the answer in my head.

Prof. McMillan: The provision of continuity of care models in public hospitals is a public hospital health system. It's not funded by the MBS; it's funded through a set of arrangements between states and the Commonwealth in relation to funding public hospitals. Access to MBS is available for what we know as endorsed or eligible midwives, who can then work independently through a set of arrangements through the Nursing and Midwifery Board of Australia. In fact, women who are patients of theirs can access MBS as a reimbursement system for care. There's work underway with the department on reviewing a number of MBS items that relate to midwifery. That is still underway, but we hope to have that completed either later this year or early next year. That will address a number of areas of anomaly in relation to eligible midwives or endorsed midwives accessing MBS items.

Senator WATERS: Thank you; that was nice and clear. I recall now that, when I asked a different official, they said that those previously agreed items under the Strengthening Medicare Taskforce were actually being

rebriefed to government and, essentially, were under reconsideration, so thanks for giving me the time frames on that consideration.

Prof. Murphy: Ms Rishniw has some more information on what the Commonwealth is doing on continuity of care.

Senator WATERS: Yes, I think it was you.

Ms Rishniw: It was. We did talk about the Strengthening Medicare Taskforce and the work underway there. I thought it was also worth mentioning that there are some other investments that came through in this budget, particularly around living evidence guidelines for pregnancy care and postnatal care. There's $5.9 million invested in actually doing living evidence guidelines to improve the care for pregnancy and postnatal care. There is also $22.9 million, I think, for Waminda, a centre of excellence for birthing on country, which will provide excellent support, evidence and best practice for First Nations women and birthing on country experiences as well. I wanted to add that to the list.

Senator WATERS: Thank you for raising that. That was on my list of questions. I'd like to know the time frame for when the Waminda Nowra centre will be operational and whether or not the department is developing a work plan for a national rollout of birthing on country initiatives.

Ms Rishniw: If you can give me some time to take that on notice, I'll be able to get some detail for you after the break.

Senator WATERS: Thank you; I'd appreciate that.

Ms Rishniw: That centre of excellence is really looking at how to develop best practice to be able to roll out best practice birthing on country initiatives across the country nationally. It is very much designed to be an evidence-based birthing on country centre for a whole range of birthing on country initiatives. I'll come back with time lines.

Senator WATERS: Thank you very much.

CHAIR: Other senators with questions have kindly agreed to put them on notice.

Food Standards Australia New Zealand

[10:16]

CHAIR: Does anyone have questions? Another senator has agreed to put their questions on notice for this agency. Is anyone seeking the call?

Senator RUSTON: I'm happy to ask a couple of questions, seeing that they've come all this way. By way of a bit of explanation, is Food Standards Australia New Zealand made up of all of the states and territories, plus New Zealand and the Commonwealth? Is Food Standards Australia governed by a federated model of Australian states and territories, the federal government and New Zealand?

Dr Cuthbert: The food regulatory system comprises quite a broad remit. We report through ministers up to the food ministers meeting, and that food ministers—

Senator RUSTON: What are food ministers?

CHAIR: Health ministers.

Dr Cuthbert: Not always. Minister Watt, for example, is also at the food ministers table.

Senator RUSTON: In terms of your ministerial body, is that constituted under some sort of statutory arrangement in that it has a power outside being an advisory body?

Dr Cuthbert: There's the FSANZ Act, which articulates our role in how the board is made up, how the board is comprised. There is also the food regulation system agreement. I'm sorry; I can't remember the title of it. That also articulates how it all works together, and it includes a treaty between Australia and New Zealand as well.

Ms Rishniw: In case it's useful, from the perspective of the department that has responsibility, the food regulation agreement—the FRA—is the agreement that Ms Cuthbert was referring to, which sets up the arrangements between the states and territories and, you're right, the Commonwealth, and New Zealand is a party to that. The Food Standards Australia and New Zealand Act 1991 actually establishes FSANZ, the board and a food ministers meeting. Food ministers attending that meeting include both health ministers and agriculture ministers, quite often, and it's jurisdictional. New Zealand is represented, all of the states and territories are represented, and often there are two ministers per jurisdiction.

Senator RUSTON: Does it require a consensus in terms of getting decisions, or is it a majority vote in terms of any propositions as to regulatory change that you would put to that ministerial council?

Ms Rishniw: That's another question for the department. Food ministers operates on a majority vote rather than consensus, but it tries to—

Senator RUSTON: A majority?

Ms Rishniw: A majority, yes. You need a majority of the food ministers, but they operate to try and reach consensus on issues.

Senator RUSTON: Do you always have two ministers per jurisdiction?

Ms Rishniw: Generally.

Senator RUSTON: The weight of the power that exists within that council absolutely sits with the states and territories.

Ms Rishniw: The food ministers meeting is chaired by the Commonwealth. There is a lead minister from each jurisdiction. As I said, it operates to try and generate consensus as much as possible, and it has often been successful in doing so. It has a weighted majority, but the chair is the Commonwealth.

Senator RUSTON: The chair has no power, outside the fact that they run the meeting. Clearly, each and every one of the members of the board has equal voting capacity.

Ms Rishniw: Yes, that's right. They run the meeting but, as I said, generally issues of contention are resolved constructively.

Senator RUSTON: In terms of regulation that sits, for instance, within the domain of the Commonwealth, as opposed to the states and territories, is there any mechanism by which, if the jurisdiction is the one that is likely to be most impacted, that jurisdiction has an ability to exert greater influence over the outcome as opposed to something that sat across all jurisdictions? It seems like a really weird model where the states and territories are wagging this dog. I'm feeling a bit sorry for New Zealand in all of this. If they've only got one person and something was impacting New Zealand, how would that get sorted out?

Ms Rishniw: The actually has fairly prescriptive roles for the board, for FSANZ, for food ministers. As I mentioned, in general, it's a really constructive discussion. There are very few issues that would impact on one jurisdiction. It operates to be a national food regulatory system and tries to drive consistency. With New Zealand, with that bi-national system, they operate and rely very heavily on the kind of scientific evidence and the evidence-based policy and standards that FSANZ actually delivers. There's absolute recognition of the independence of FSANZ and the evidence-based advice there. As I say, it's very rare for a national food issue to only impact on one jurisdiction disproportionately. It's exactly why the legislation and the organisation exist.

Senator RUSTON: As an example, Dr Cuthbert, can you tell me of a time when you haven't been able to reach consensus on a particular regulation?

Dr Cuthbert: A lot of the work that we do requires a lot of consultation throughout our processes. All of our proposals and applications go through rigorous consultation and, most times, there are differing views as to where we should go with those. I can think of many examples where we have to work through and understand the issues that face each stakeholder in the system, and we work through that very transparently, very openly and listen to everybody's point of view. Often, on a significant piece of work, we go through more than one round of consultation to make sure that we've heard those views and we're moving forward in a way that will suit the majority.

Mrs Leemhuis: Perhaps I can add to that. New Zealand does have an opt-out of standards. An example that you're looking for was one around folic acid. I can't remember the time frames for that; it was a number of years ago. New Zealand opted out of that standard at the time, so it only came into play in Australia. Of course, the Food Standards Code is set up in chapters. You have chapters 1 and 2, which are across the bi-national system, and chapters 3 and 4, which just relate to the Australian system. Folic acid is an example where New Zealand did opt out; but, more recently, they've been looking to introduce that standard.

Senator RUSTON: You said that there were lead ministers; do I assume that, with the so-called voting or whatever you want to call it, there is only one minister from each jurisdiction who gets to be the person who casts the vote?

Ms Rishniw: Generally, all ministers attend and the jurisdictions will caucus between ministers; but, yes, there's one vote per jurisdiction.

Senator RUSTON: Is it up to the jurisdiction to decide which of the two ministers that is?

Ms Rishniw: It is.

Senator RUSTON: Is there an even balance between being the ag minister and the health minister, or is it more predominantly one or the other?

Ms Rishniw: I will have to take that on notice, in terms of the current food ministers meeting arrangements, if I can. Generally, it is well balanced.

Senator RUSTON: I can see how you would have quite significant competing interests between health and agriculture. I find myself in that place often in this new job, having come from agriculture, in terms of how to assess the impact of a regulation regarding the benefits versus the implications it has, particularly for food. To that end, you both made comment about evidence-based advice. Obviously, one of the hot issues at the moment is pregnancy labelling on wine. What was the evidence base that sits behind the decision to pursue these quite significant label requirements for the wine industry on pregnancy? What was the underlying evidence base that suggested that wine in a bottle was a significant issue in relation to pregnancy and medical implications with the consumption of alcohol during pregnancy?

Dr Cuthbert: I'll pass to Mr Neal, General Manager of Risk Management and Intelligence, on this one.

Dr Neal: In terms of the pregnancy warning labelling changes that came into play in 2020, they apply across the board for all alcoholic beverages. Essentially, they were the culmination of a ministerial request following a voluntary program that was in operation by the alcohol sector for about the last 10 years. Essentially, the weight of evidence unified to the point where there is an undeniable link between the consumption of alcohol during pregnancy and the sequela known as 'foetal alcohol spectrum disorder', a range of—

Senator RUSTON: I want to take a step back. I don't think I'm disputing that drinking alcohol in excessive quantities is probably not the smartest thing to be doing while you're pregnant. I was specifically asking what the evidence base was in relation to the consumption of wine from a bottle. Clearly, alcohol comes in many forms and not just in a wine bottle, so why particularly was wine, premium wine, targeted for this particular measure? What was the evidence base to suggest that was the 'problem child' in terms of alcohol-related pregnancy issues?

Dr Neal: The evidence base related to the amount of foetal alcohol spectrum disorder that was occurring in the community and consumer literature around the number of people who didn't quite understand the connection regarding the consumption of alcohol. There was nothing specific to wine; it was decided to apply the warning label to all types of alcoholic beverages in Australia and New Zealand.

Senator RUSTON: My understanding is that you're currently reviewing the colour requirements in relation to this particular measure. I'm interested in understanding the nature of the determination in relation to this. This doesn't have to come into effect until next year, does it?

Dr Neal: That's right. There is a three-year transition that is in play for that rule, so 1 August 2023 is the deadline. What has transpired is that, for a small number of packages of alcohol—those transported and sold in a corrugated cardboard outer—there's a technical impediment to getting the three-colour label design printed in a clear manner, using that technology. We're talking about exempting a small number of those cardboard outers that this relates to. That's a particular application from the alcohol sector to find a solution around a very small number of those packages.

Senator RUSTON: Do you do a cost-benefit analysis on these decisions?

Dr Neal: Yes, absolutely. We're required by the act to undertake a detailed cost-benefit assessment and prepare, quite often, a regulatory impact statement as well, that receives the scrutiny of the Office of Best Practice Regulation.

Senator RUSTON: Would it be possible to provide me with a specific cost-benefit analysis in relation to bottled wine, as to what the additional cost would be on manufacture, the cost of the changes to this regulation on that particular part of the sector and what you believe the benefit analysis is on that?

Dr Cuthbert: We have the cost-benefit for the label changes. I don't know whether our cost-benefit went into the detail specifically for bottled wine. We'll look into that, and we'll make sure that we provide what we have. It is probably available, and we'll circulate that.

Senator RUSTON: I suppose I'm being critical of the one-size-fits-all approach because the damage to a particular subset of the industry that is being impacted may be significant, but their contribution to the problem may be negligible. Clearly, you take a blanket approach and everybody gets put into the basket. You do your cost-benefit analysis across the entire sector and you're not having any regard for the fact that there could be a subset of that sector that is not making any great contribution to the problem, yet you don't take into account the disproportionate impact of the cost and the consequences for that sector. I'd be interested in understanding how you deal with that and why you don't deal with that. I'd be very interested to understand from the ministers why

they're not requiring you to undertake that, and why our agriculture ministers aren't sticking up, if that's the case and the circumstances.

CHAIR: Thank you, Senator Ruston. I believe that's all of our questions for you. Thanks for your attendance today. You are free to leave.

National Rural Health Commissioner

[10:31]

CHAIR: We will now move to the National Rural Health Commissioner. Senator Waters will kick off here.

Senator WATERS: Thanks for joining us today. I'd like to ask some questions about rural and regional access to reproductive health care, predominantly access to abortion, but I'm also interested in access to the full range of maternal health options for pregnant people across the country. I'm actually not sure who's best placed to answer this, so forgive me, Professor Stewart, if I direct something to you that the department might need to answer. I'm interested in what data collection is done regarding abortion care, both medical and surgical, in Australia; in particular, do you break that down for rural and regional areas?

Prof. Stewart: I am not the person who can answer on data collection. I can answer on workforce issues and matters that affect those, but not the data collection.

Prof. Murphy: We can bring some officials to the table.

Senator WATERS: While that person is joining us, I am interested in whether we keep data on how many abortions are performed in public hospitals.

Ms Rishniw: Could you repeat the question?

Senator WATERS: Yes. I am interested in what data collection is done regarding abortion care, both medical and surgical, across the country. Do you keep figures on how many abortions are performed in public hospitals, and is there a rural and regional breakdown for those figures?

Ms Rishniw: My understanding is that there isn't any national collection that looks at terminations in a statistical way across all jurisdictions, and a breakdown. I will have to take that on notice, if I can. I haven't seen any consistent data nationally on those figures.

Senator WATERS: Why is that data not collected?

Prof. Murphy: Part of the problem is that, with the MBS data, the MBS codes are used for more than just termination of pregnancy, for abortion. Some of those codes are used for other indications. The MBS is often our richest set of data for the private medical sector, but if you pull out the codes for surgical abortion, in that database there will be a number of other procedures that are done for other things. Obviously, in the states, and in the public system, there is rich data because that is coded under the National Health Reform Agreement, and those data are reported through. AIHW could pull that together, and we could pull that data together from the states. The states and territories certainly have data on their public abortions.

There are, of course, medical abortions, which is the other side of things. We can get some data on that through the PBS, in terms of the prescriptions. It is possible to pull it together, but, as Ms Rishniw says, there isn't a comprehensive dataset. This is certainly a very strong interest of Assistant Minister Kearney, and she is very keen for us to do more work in this space. It's clearly a program of work on which we're commencing to expand our efforts.

Ms Rishniw: We can take that on notice, and we'll pull together the data that we can easily do.

Senator WATERS: Thank you. That would be wonderful. I share Minister Kearney's commitment to this area, so let's hope we can improve access for women across the country. Professor Stewart?

Prof. Stewart: Another complication is that the PBS data looks at the provision of medical termination under PBS, but it doesn't look at when those medications are given within a public hospital.

Senator WATERS: I see.

Prof. Stewart: Particularly in rural and remote communities, it's far more likely that a medical termination will be managed by a hospital.

Senator WATERS: That's right; because of the follow-up care required. I'll look forward to seeing those figures. MSI International was forced to withdraw a number of regional abortion services in 2020-21 because government subsidies were not sufficient for the services to break even. Have you studied the impact of that removal of services on women's access to termination services?

Prof. Stewart: I haven't conducted a formal study, but I've certainly received feedback that it has increased the difficulty for some women in accessing termination services.

Senator WATERS: Have the minister, the government or the department met with MSI since the election to discuss any funding model that would allow services to be increased?

Ms Rishniw: I can't comment, obviously, on whether ministers have met with MSI. Since the election, I'd need to take that on notice, in terms of whether we had met with MSI. But the department have met regularly with MSI. One of the other things that was very clearly communicated by MSI, particularly during COVID, was access to telehealth services as well. That was very specifically an initiative that was in response to some of the feedback from MSI. I would need to take on notice whether we've had any meeting since the election. As I said, I couldn't comment on whether ministers have met.

Senator WATERS: Thank you. It's really more about whether or not alternative funding models are under consideration by government or by the department. Is that work being done?

Ms Rishniw: A lot of the services, obviously, are state and territory run, so we've been talking to states and territories in that space. In terms of specific modelling of MSI's viability in that space, there has been nothing specific yet.

Senator WATERS: Since the election has the department briefed the minister or the assistant minister on abortion access issues across the country or on models of delivery in other countries—or, indeed, you, Professor Stewart? Has anyone briefed the minister on those issues?

Prof. Stewart: No, I have not briefed the minister on this matter.

Ms Rishniw: We have briefed ministers in the normal course of briefing and providing advice to government.

Senator WATERS: Have the department or the minister asked the Strengthening Medicare Taskforce to consider creating new Medicare items for abortion care?

Prof. Murphy: The Strengthening Medicare Taskforce is primarily looking at primary care generally. Minister Butler has focused it on what he sees as, rightly, the crisis in general practice and getting primary care. It's largely focused on that. It's not a broad review of the MBS as such. We have an ongoing, continuous MBS review, as we have talked about before, looking at things like midwifery. The Medical Services Advisory Committee, which Ms Shakespeare is responsible for, looks at MBS changes from time to time. I don't know whether there have been any MSAC approaches about—

Ms Shakespeare: There have been no recent approaches to MSAC on this issue. I think that there's currently an application in to TGA to expand the ARTG listing for the medical termination pharmaceuticals, which may then flow on to changes to the Pharmaceutical Benefits Scheme.

Senator WATERS: Unfortunately, I can't be here when TGA is appearing, so I appreciate your flagging that. I'll put some questions on notice for them.

Prof. Murphy: The TGA dep sec is online from Dublin, just for you, if you want to ask him about that.

Senator WATERS: Yes, please.

Dr Skerritt: We have had discussions with MSI about changes to the conditions which would liberalise access. Currently, there's a rather stringent training program—this is for doctors and pharmacists—and this is seen as a block. We have also met with our advisory committee for women's health products, in which Assistant Minister Kearney actively took part just last month. We discussed how medical abortion access could be widened. At least as of my most recent advice, a week and a half ago, we haven't yet received an application from MSI. I should add, however, that these products are generic. One thing that we have been talking about with the relevant peak bodies in this area is the ability for an alternative company to come forward with an application. Sometimes competition in the market may actually open up access to medical abortion more widely in Australia.

Senator WATERS: Thank you. I will put some questions on notice because I've got quite a lot there. I'm getting the look from the chair to finish up, so forgive me for not going down that path with you right now. Can I finish by asking: are there any commitments in the budget to provide for period poverty, abortion care or the impacts of menopause?

Ms Rishniw: There's a range of commitments, particularly around, as we were discussing, rather than menopause specifically, the commitment and a recent announcement to open 16 clinics across the country, particularly around pelvic pain.

Senator WATERS: I was at that announcement yesterday. I am interested in period poverty, abortion care and the impacts of menopause.

Ms Rishniw: The government has committed to working alongside state and territory governments to improve standards of care and access. In terms of specifics in funding, nothing there; obviously, there's the consciousness of the Senate inquiry coming up, so the department would be making a submission to that. In terms of, as I said, endometriosis and pelvic pain, there are certainly commitments there.

Senator WATERS: I welcome those. It's not that they're not important; it's just that I'm already across those details.

This is my final question. Thank you, Chair, for your patience. Professor Stewart, perhaps this is one for you: is there any data collection, or can you tell me about the state of access to maternity services for people across the country, particularly in rural and regional areas? The anecdotes that I hear are that pregnant people have to travel, sometimes for hours, which is thoroughly impractical when you're about to give birth. It's a real issue in the community.

Prof. Stewart: Yes, it is a real issue. There is data. It does tend to be broken down according to each state and jurisdiction. It can be found in various places, including published papers. We do know that there has been a decrease in the number of maternity services, with a particular decrease in rural and remote communities, and of smaller birthing services. In the last five years there has been a slight increase in the number of rural birthing services, however, with Queensland being particularly active in that space.

Senator WATERS: This is my final question, I promise: is the government doing anything to address that decrease in services?

Prof. Murphy: Certainly, in the recent budget, there was some money put aside to work with New South Wales Health on potentially re-establishing birthing services in Yass, which was an election commitment of the government. Of course, we heard about the Waminda centre. They are, again, fairly small issues. The biggest challenge is that the states and territories have generally closed these services. It's quite an active debate. The basis for closing services is that they don't feel it's necessarily safe to operate with low numbers of births. Rural generalists and Professor Stewart's colleagues would say that's not necessarily an evidence-based assertion, and that the risks associated with travel can often outweigh the risks of having these services.

It's a matter of getting that critical mass of midwives and GP-obstetricians to make those services viable. I think that many of the states and territories are trying to work to re-establish them, but it is largely their regulatory environment that has led to that.

Obviously, the Commonwealth, under the passion of Professor Stewart and her colleagues, is trying to expand our rural generalist pool. Some of the most important rural generalists are those with obstetric experience and, accompanying that, rural generalists with anaesthetic experience. If we can get that medical workforce up, the other side of it is getting the midwifery workforce.

We're doing what we can in the workforce space. In terms of whether those services are open or closed, it's ultimately a decision for the state and territory governments.

Ms Shakespeare: In terms of specific announcements, we do have some to support rural generalists to acquire those procedural skills, including obstetric skills. The recent budget included $10.7 million in funding to increase the number of procedural training places. That's working with states and territories so that we can increase the number. There are existing training programs to support rural GPs to acquire procedural skills and maintain those, but this is an additional investment. There is an additional $74.1 million invested over four years to increase incentive payments to rural generalists who have procedural skills and are using those to deliver expanded skills in their communities, including obstetric skills. There are some specific investments that will benefit obstetric care in rural areas.

In the March budget this year, there was also investment. I don't have the number here with me. That has allowed us to employ a principal midwifery officer in the department, who works to our Chief Nursing and Midwifery Officer, Professor McMillan, who is also doing work with the states and territories around rural maternity services access. There are a few things happening at the moment.

Senator WATERS: Could you take on notice for me the work scope of that most recent person? Thank you very much, Chair, for your generosity, and thanks for your time, everyone.

CHAIR: Before I hand over to Senator Ruston, I need to alert the committee that the media have requested permission to film and take photographs of the proceedings. I'm seeking your agreement. Thank you. I remind the media that this permission can be revoked at any time, and you must follow the direction of secretariat staff. If a witness objects to filming, the committee will consider this request. The media are also reminded that they are not able to take images of senators' or witnesses' documents or of the audience. Media activity may not occur during

suspensions or after the adjournment of proceedings. Copies of resolution 3 concerning the broadcasting of committee proceedings are available from the secretariat. Senator Ruston has the call.

Senator RUSTON: Professor Stewart, thank you very much for the amazing work you do on behalf of rural and regional Australia. Do you have in your role—maybe the department does—an analysis in terms of the workforce distribution? Do we have a map, in terms of workforce shortages and vacancies, as per geographical locations?

Mr Williams: Yes, we have two efforts underway at the moment in terms of two key workforces, which is the medical workforce and the nursing workforce. We have done a supply and demand study for both workforces and are currently undergoing testing of the modelling externally, to be able to identify exactly where the shortages are. Those shortages will be determined not only by vacancies and the workforce distribution but also the conditions that Australians face and that need to be treated. The modelling that is being undertaken accounts for the significant evolution in chronic and other conditions in Australia. We do have the distribution priority area program as well, which does—

Senator RUSTON: Don't go to that. I'll come to that in a moment. Stick with the modelling in relation to workforce shortage, if you wouldn't mind.

Mr Williams: That modelling is underway. We don't have that publicly available, but we are testing that externally. There is currently an agreement with the University of Adelaide that we've undertaken to test that modelling.

Senator RUSTON: When is it likely that will be available?

Mr Williams: Consultation will be undertaken with the sector as well as with academia and those who are relevant. We're hoping that will be publicly available soon.

Senator RUSTON: Any idea what 'soon' means?

Ms Shakespeare: I think it will be different for different parts of the profession. We will need to work through the nursing supply and demand study with a range of employers and training organisations to test the model. There's a separate—

Senator RUSTON: Who actually undertook the research to determine workforce shortage?

Ms Shakespeare: The modelling is being done by a team of health workforce modellers in the department, but it does need to be tested with external experts first. We are doing a range of modelling across medical specialties under the National Medical Workforce Strategy. One of the key recommendations was that we needed to be doing supply and demand modelling for each of the professions because we will need more of some professions in some locations; we will need less of some professions in some locations. For general practice, we also have the HeaDs UPP data tool, which has been developed, and it tracks five years worth of Medicare service provision, primary care service provision, showing where people are accessing their services. It looks at both the location of the Medicare cardholder and where they're accessing their services. That tool is available to people in state and territory governments to assist with workforce planning, and to some others that I think have been given access under arrangements that comply with the Health Insurance Act requirements for the protection of data.

Senator RUSTON: In terms of the research that you're doing on, for instance, GP, are you also analysing the use of MBS items per location? Will that give you an idea in terms of the level of potential under-servicing that may well be occurring in rural, regional and remote areas?

Ms Shakespeare: Yes.

Senator RUSTON: When will that be available?

Ms Shakespeare: Some of that HeaDs UPP data modelling, showing where people are accessing services and the level of service access, is already available to staff in the department. We use that—

Senator RUSTON: When will I be able to see it?

Ms Shakespeare: There are difficulties that we have to work through in terms of public release of information at that level because of provisions in the Health Insurance Act that make it a criminal offence to release information about individuals, whether that's providers or individuals who access health services, which could lead to re-identification. We can certainly make more information available, but we have to make sure that it is not going to identify individuals, which can be a problem, particularly when you go to small or remote locations.

Senator RUSTON: I get that. It is in the public interest, I would have thought, for a community to understand what's actually happening in relation to the provision of health services within that community. You don't have to

name Dr Bloggs, but in terms of postcodes, everybody knows in shallow markets who's there, anyway. I am interested in understanding what would be your argument in relation to not providing—

Ms Shakespeare: We do provide information through the distribution priority area updates as to which locations are under-served for primary care services.

Senator RUSTON: I get that; but we are talking about servicing. Equally, it could show over-servicing, couldn't it? It would show a discrepancy in the servicing of particular communities, whether they're in a city or whether they're in a country area. In the case of, say, urgent care clinics, how does a determination get made in relation to that if you don't know what the servicing is? It seems to me to be a very non-transparent way of going about things.

Ms Shakespeare: We do have good information about Medicare services. We publish a lot of information at levels where you don't identify individuals. With providing more granular, detailed information, we can look into that. We often get specific requests for information about Medicare services in particular locations. But we do have to assess them to make sure that we don't identify individuals.

Senator RUSTON: If I put a question on notice to the department and requested, by postcode, the workforce and MBS item numbers, would you be able to provide me with that data, or would you not?

Ms Shakespeare: I think we'd need to look at the request and make a decision based on whether there were small cells involved.

Mr Williams: We normally record data by general practice catchment, which is basically an analysis of where patients and individuals actually acquire services, and services are provided to them. For the geographic boundaries, we use general practice catchments. We can provide that information for you.

Senator RUSTON: Through PHNs?

Ms Shakespeare: There are 827 general practice catchments across Australia.

Senator RUSTON: You would provide the data at that level?

Ms Shakespeare: I think that, at that level, it's usually fine—

Senator RUSTON: Is it published?

Ms Shakespeare: Those are published for DPA. We base distribution priority areas at catchment level. It will be in many cases, yes.

Senator RUSTON: Going on to the DPA, when the DPA was first conceived as an initiative, what was the purpose of it?

Ms Shakespeare: I don't know exactly when districts of workforce shortage were first conceived. It was probably in the late 1990s, but I'd have to take that on notice. Distribution priority areas replaced districts of workforce shortage for primary care practitioners in, I think, 2018 or 2019.

Mr Williams: 2019.

Ms Shakespeare: 2019, my colleague reminds me. That was designed to take a far more targeted approach to distribution challenges faced in the primary care catchments. District of workforce shortage looks at overall service numbers compared to a national average, whereas the distribution priority area looks more at the health needs within those 827 catchments. It takes into account service-level usage and socio-economic data to try and work out what should be the service level for a community, rather than just applying a national average. It was an improvement on the earlier district of workforce shortage system.

Senator RUSTON: At the time that the DPA was implemented, was there any explicit requirement in relation to it being focused on rural, regional and remote?

Ms Shakespeare: The use of the distribution priority area is primarily for a couple of programs. One is section 19AB of the Health Insurance Act.

Senator RUSTON: I know exactly why it is there. That wasn't the question I asked you, with the greatest respect.

Ms Shakespeare: It's for the use of those programs. Those programs do—

Senator RUSTON: To where? I am trying to understand: was there any—

Ms Shakespeare: It's for areas of workforce shortage, so it's not purely rural and remote areas.

Senator RUSTON: There was no intention, at the time DPA was put in place, that it was there to solve a specific challenge in relation to the recruitment of workforce, particularly GP, in rural, regional and remote Australia?

Ms Shakespeare: It's there to support effective distribution of overseas-trained doctors and foreign graduates of accredited medical schools to areas of workforce shortage, and those that are completing return of service obligations under our bonded medical programs.

Senator RUSTON: To be really clear—and I heard exactly what you've just said—at the time it was introduced, was there any intention for it to be focused on rural, regional and remote areas?

Ms Shakespeare: It's there to support effective distribution of overseas-trained doctors and foreign graduates of accredited medical schools to areas of workforce shortage, and also those that are completing return of service obligations under our Bonded Medical Program.

Senator RUSTON: Just to be really clear—and I heard exactly what you just said—at the time it was introduced was there any intention for it to be focused on a rural, regional and remote areas?

Ms Shakespeare: Distribution priority area is a system of classification—

Senator RUSTON: No, no. Ms Shakespeare, I understand that.

Ms Shakespeare: that is based on 827 GP catchments.

Senator RUSTON: I understand. All I want you to say is yes or no, or maybe, if the secretary wants to take it up to that level. I just clearly want to understand whether, when the program was put in place, it was targeted at rural, regional and remote areas, or whether it was targeted at all areas of workforce shortage but there just didn't happen to be workforce shortages anywhere apart from rural, regional and remote.

Prof. Murphy: I think we'd have to go back to the history, Senator. But I think what you're saying is right; it was targeted at areas—as in the name of the original measure, 'district of workforce shortage'—where there was clearly an undersupply of any sort of medical specialists, GPs or other specialists. In the main, probably, at the time it was introduced that would have been more prevalent in rural and regional areas, but there have always been some districts of workforce shortage—for example, parts of major towns and even in Tasmania. All of Tasmania, I think, was classified at some stage. Clearly, rural and regional are the most important parts where we have shortages, but they are also very prevalent in other places. But, in terms of the original intent of the measure that preceded DPA, we'd have to go back and look at the history of it.

Senator RUSTON: I'm really dealing more with DPA. To that point: when DPA was introduced—three, four or five years ago—were there any DPA areas that would have been considered parts of major capital city populations? Obviously, I understand the Northern Territory is quite a unique case, but did Sydney or Melbourne or Brisbane have any DPA classifications when it was first introduced?

Ms Shakespeare: Yes, in outer metro areas. That depends on the level of service, but there could be classification of outer metro areas of the capital cities as DPA.

CHAIR: Thanks, Senator Ruston. It being 11.02, the committee is now going to suspend for morning tea.

Proceedings suspended from 11:02 to 11:17

CHAIR: The committee will now resume. I understand that the senators who requested the Organ and Tissue Authority have agreed to place their questions on notice. Unless there are any senators at the table seeking questions from them, we're happy to dismiss that agency.

Prof. Murphy: We'll let the officials from the OTA go.

CHAIR: Okay. Then we will be returning to questions to the National Rural Health Commissioner and working through in that order. Senator Ruston, I understand you had further questions for the commissioner.

Senator RUSTON: I'm happy to come back to Mr Williams and Ms Shakespeare around the whole DPA workforce shortage issue, but I'm just interested to get your views, Dr Stewart, on the decision in July to expand the DPAs into a number of outer metro areas and whether you have any comments as to what the impact of that has been or might be into the future on the rural, regional and remote workforce, particularly IMGs.

Prof. Stewart: I suppose my views about the effectiveness of the DPA really predate any decisions that were made this year. As you're well aware, we have not been able to turn the tide on rural health workforce. Despite the DPA being very much focused on rural and remote areas, it hasn't delivered a strong rural health workforce. So I don't see there being a great impact of changes to the program that have been made this year.

Senator RUSTON: I'm just going to read a quote to you from a release from the Rural Doctors Association of Australia—from Megan Belot, who's the president. She's saying that she, or the RDA, was extremely disappointed to see Labor persist with this policy change despite strong opposition from rural doctors. I suppose my question to you is: even though it didn't solve the problem, are you suggesting that Dr Belot's concerns were

unfounded—you don't believe that the expansion of the DPAs into peri-urban and outer metro potentially could have a negative impact?

Prof. Stewart: I share Dr Belot's concern that it could have a negative impact. I'm waiting to see what the impact is. I think that the situation is far more complex and we try to reduce it to simple cause and effect. But what we do know about the rural health workforce is that there are many different contributors to people's decisions about whether they work in a rural community or not.

Senator RUSTON: In your an assessment as to whether this or any other initiative that's in place or changed or removed or put in place in relation to regional and remote workforce, do you have a role in analysing those impacts?

Prof. Stewart: My role is to engage with key stakeholders in rural and remote health and to listen. I have heard specific instances where health services have lost a doctor who has decided to move to an MM 2 or MM 1 location, but I'm yet to see a nationwide impact of such movements. It's really easy to focus on that loss and not see it in the context of the broader rural health workforce.

Senator RUSTON: Yes, absolutely. I wasn't suggesting for a minute that this is the only thing that was going to impact on the rural, regional and remote Australian workforce. But I suppose it's just interesting. To date, we've had comments from people in Huonville in Tasmania. We've got a situation on the west coast and Wudinna in South Australia and the Tristar medical clinic closures. We've seen that all of their IMGs almost without exception—those that haven't been picked up by other clinics—have gone. They've got the opportunity to go back to the city. And I just sort of wondered who is undertaking the assessment around the movement of this workforce and when are we likely to address that.

Prof. Murphy: I can address that. We are monitoring it very closely.

Ms Shakespeare: That's correct. We are closely monitoring movements in doctors—overseas trained doctors. The changes to the DPA arrangements came into effect on 21 July. So we've only really got a few months worth of data to look at, at this stage. I think we need to continue to closely monitor what's happening. But, to date, the movements that we're seeing are within normal ranges.

Senator RUSTON: When the decision was made to make this expansion on the DPAs, did the department do any analysis on what the potential impact might be on workforce movements from areas of extreme and critical need into areas of high need and did you provide that advice to the minister?

Ms Shakespeare: Many of the changes that took effect in July implemented election commitments. The department did not advise on the development of those commitments, as you'd expect. We've certainly done a lot of analysis in terms of preparing for the changes. And, as I said, we're monitoring the impacts in terms of flows of doctors between different locations.

Senator RUSTON: Minister, I'm just wondering, given that you come from rural, remote and regional communities, whether you would have any idea as to whether there was any research or consultation undertaken by rural, regional and remote communities, which I know you very passionately represent, as to the impact of the decision that came into effect in July on those communities.

Senator McCarthy: Senator Ruston, not in terms of the decision in July. I am constantly out on the road in regional and rural areas and speaking to, largely in my area, the Aboriginal community controlled health sector. There is no doubt that we have to look very closely at the workforce issue, not just in health but right across the board—tourism, the roadside stops that we're at. So we're very aware and we're certainly on top of it. We're trying to see what we can do.

Senator RUSTON: In your travels, have you had any concerns raised with you about the potential impact of DPAs—the changes—on rural, regional and remote communities that you've been speaking to?

Senator McCarthy: As I said, no.

Senator RUSTON: Okay. Clearly, they're not speaking to you. I would have thought they would have been.

Senator McCarthy: Well, you're asking me about their concerns, but they haven't raised any with me.

Senator RUSTON: No, absolutely. That's absolutely fine. So, to the best of your knowledge, there was no consultation specifically about the changes undertaken in the rural and remote communities that you spend a lot of time in?

Senator McCarthy: I've understood your question to be whether I personally have received that kind of information on my consults, and the answer is no.

Senator RUSTON: All right, well, I'll ask the question again. Are you aware of any consultation that was undertaken with rural, regional and remote communities before the decision was implemented?

Senator McCarthy: No, I'm not aware.

Senator RUSTON: You're not aware? Okay. Would it be possible to take on notice, then, Minister, to find out what the basis of the decision was and whether the implications on rural, regional and remote communities were taken into account when the election commitment for changing the DPAs was made? Also, I'd be interested in your views as to the concerns that were expressed by the Rural Doctors Association of Australia.

Senator McCarthy: I'm happy to take that on notice.

Senator RUSTON: Just finally, Professor Stewart, do you undertake a holistic mapping around workforce shortages and particularly around vacancies in rural, regional and remote Australia or is that something that the department does?

Prof. Stewart: That's something that the department does. My role is more consultation and engagement and, from that engagement, formulating advice for the department.

Senator RUSTON: In the formulation of that advice from the consultation, have you formed a view as to what are the driving factors around decisions of medical graduates, for instance, to become a rural generalists or, just more generally, what are the things that you believe in your consultations are the barriers to Australian health professionals operating in rural, regional and remote areas? What do you think would be the most advised thing to do or advised things to do in order to alleviate the problems that you have found in your consultations?

Prof. Stewart: The rural health workforce shortage has been a long time coming and, as you might expect from that, there are many contributing factors. I think that one of the major issues is that our health professionals are largely educated in universities and many of those universities are placed in large urban centres. If we want health professionals to work in rural and remote communities, the best predictor is to have a student who came from a rural or remote community. If you have the university in the large cities, that's immediately a barrier to many rural students to move to the city. It's a financial barrier and a social barrier. Australian governments of all persuasions have invested over the last 25 years in the Rural Health Multidisciplinary Training program, which has gradually built, in an iterative process, a lot of knowledge and infrastructure to increase training in rural and remote Australia. Certainly, in my role, I am contacted quite often, via overseas agencies, by people wanting to learn from what Australia has learnt about education in rural and remote Australia.

So it is educating rural origin students and giving them frequent, well-supported exposure to clinical attachments in rural and remote areas so that they understand what rural practice is, what the benefits are and how to manage the difficulties. Then they need a clear line of sight to a training pathway for their postgraduate years so that they can specialise in the skill set to deliver care in a rural and remote setting. In medicine, we have the National Rural Generalist Pathway. In allied health, we have an Allied Health Rural Generalist Pathway that has been developed and is expanding. In nursing, one of the deputy rural health commissioners has led work on the development of the national rural and remote generalist pathway for nursing. I've got that name a little bit wrong. It's RRNG. We recognise that people are far more likely to go and work in rural and remote when they understand what the skills are that are needed, when they have experience in rural and remote communities and when they're familiar with it. It's not a scary environment. Then we know that it does make a difference if you recognise, financially, that skill set. That leads me to the next issue. In the last 20 years, general practice in Australia has become one of the specialties that is far less attractive to new graduates. I think that underlies a lot of our difficulty in attracting medical graduates into rural and remote Australia because, really, what we need—with the majority of our doctors in rural and remote Australia, we need them to be general practitioners. We particularly need them to be rural generalists. We are working hard to develop that National Rural Generalist Pathway. So there are a lot of different ways that we are approaching the issue.

I've spoken quite a bit about the medical pathway. I think that we ignore or don't talk enough about the shortage of allied health practitioners. I feel that's because the way that health care has changed in the last 50 years has been to call upon a whole team. But that whole team has not existed in rural and remote Australia. So, in a small town that has just lost their doctor, they'll come knocking on your door saying, 'We've lost our doctor'. But, if they've never had an allied health practitioner, they don't come saying, 'We haven't got an allied health practitioner', because they don't have an understanding of what could be provided by that. I've been reading work on identifying what a rural multidisciplinary health team does. That's the Ngayubah Gadan consensus statement. I believe that will help give communities an understanding of what they need and therefore what they should be planning for. I could keep on talking for hours, but I'm sure that Senator Smith wants me to stop.

CHAIR: It's Senator Ruston's time, so—

Senator RUSTON: Yes, I'd be very interested to get some more information about innovative models of care, particularly around that whole multidisciplinary approach in smaller communities and how you can come up with innovative models that allow you to still do that. Clearly a little tiny town can't afford 16 medical specialists, but there are ways and means in which that can be delivered. I really appreciate it. I'd chew your ear off all day if I had the time, but I will cede to my colleague Senator McKenzie.

Senator McKENZIE: It's great to see you, Commissioner, in your role, and Secretary Murphy too. Congratulations to both of you. I would like to ask: has the health minister met with you since the election?

Prof. Stewart: I've met with the health minister on a number of occasions, face to face, in different committees. I've met with the Assistant Minister for Rural and Regional Health on a regular basis.

Senator McKENZIE: In terms of the waiving of HECS for medical—particularly doctors, I'm interested in what mechanisms around breaching those obligations would have. In the past, obviously, there have been schemes where medical students would give a commitment to go to rural and regional communities, but then they would be—we always said it was not successful because the students would write a letter to somebody and get out of it very easily. So that onus of responsibility back to the taxpayer and the broader needs didn't actually occur. What mechanisms should be around to sort of ensure that the old bonded arrangement works this time around?

Ms Shakespeare: The HECS-HELP scheme that was announced—I can't remember which update, I'm sorry, but it was in the last 18 months—is subject to the passage of legislation still, so it hasn't started. The legislation still needs to be considered, obviously, through the parliament. I think the final form of that will probably impact on compliance arrangements around it.

Senator McKENZIE: What advice within the department would you be considering to make sure you don't get the same outcome as we did last time, where basically you could write a letter that you've got a boyfriend now that lives in Melbourne and you don't need to go to Mildura?

Ms Shakespeare: In the way that it was envisaged when the program was announced, the HECS forgiveness would actually occur when people were working in rural areas. So it wouldn't be a case like the scheme that we had, I think, about 10 years ago that people just got the payment and then they didn't—they might have used it for television or something, rather than HECS debts as well.

Senator McKENZIE: Thank you. Minister, I'm just following up on one of Senator Ruston's questions. On the implementation of Labor's election commitment, what was the methodology or evidence that particular policy was based on?

Senator McCarthy: I'm happy to take that on notice for you, Senator McKenzie.

Senator McKENZIE: Could the department assist?

Prof. Murphy: Well, again, we have no role in determining—

Senator McKENZIE: No, that was an election commitment that was made, and I know how thorough you are, Professor Murphy.

Prof. Murphy: Yes. Our advice was that it was based on the significant evidence of shortages in out-of-metropolitan areas, GP practices under serious pressure and a desire to make a commitment to address particularly some of those MM 2 areas that were seen to have significant GP shortages. But that's all we were told. We were not involved in the developing the election commitment.

Ms Shakespeare: And I think there was a parliamentary inquiry this committee held that looked at—

Senator McKENZIE: No-one's debating, as Senator Ruston said, high need versus crisis. No-one's negating that there is a high need in peri-urban areas. But, Minister, surely the Labor Party, before they made that election commitment, assessed the impact of that election commitment on the very communities yourself represent and I represent and the types of communities that Senator Ruston, indeed, grew up in.

Senator McCarthy: Look, I'm sure there's information there that we can provide to you. As I said, I'm happy to take that question on notice.

Senator McKENZIE: But you don't know?

Senator McCarthy: You guys had two health ministers and you still don't know—

CHAIR: Senator McKenzie has taken that on notice, so can we move on.

Senator McKENZIE: It's so typical, right?

Senator McCarthy: I'm happy to bring back some questions on notice.

Senator McKENZIE: No, it's so typical. We've just heard from the health commissioner the importance of training country kids in country places, and that is actually a key reason why the health shortage exists. The data does not lie. There have been cuts in the budget handed down a couple of weeks ago by the Labor Party—a wet lab in Mildura that would actually assist in the training of allied health professionals has been cut. That $27 million commitment with Southern Cross University in Coffs Harbour, which was to actually train allied health professionals in regional New South Wales and provide a clinic facility for that community, has been cut. Another project, which was a partnership between La Trobe University and Golden Valley Health in Shepparton to train, again, allied health professionals, particularly a nursing workforce, has been cut. Can you confirm that those three projects have been cut from the budget?

Senator McCarthy: Senator McKenzie, I'm unable to confirm that, because I'd like to have a look at it.

Senator McKENZIE: Really? It's budget estimates.

Senator McCarthy: I'd like to have a look at it. But what I can say—

Senator McKENZIE: Could you do that today?

Senator McCarthy: with the portfolio areas that I have is that we have certainly injected significant funds into areas of employment of 500 Aboriginal health workers. So I'm more than happy to get back to you on the questions that you've asked.

Senator McKENZIE: I would appreciate that today, given we're in budget estimates.

CHAIR: Senator McKenzie, the minister has indicated that she will take it on notice. Can we move to the next question, please.

Senator McKENZIE: Chair, I'm able to ask my questions and I find it incredible—

CHAIR: I'm asking you to ask a question.

Senator McKENZIE: I find it incredible—

CHAIR: Senator McKenzie, I have the call. I am asking you to proceed to your next question. If we keep the dialogue to a minimum we'll get through the content quicker. Senator McKenzie, you have the call.

Senator McKENZIE: I find it incredible that here we are in budget estimates and the government cannot answer very simple questions. We were told that the government was going line by line through all these projects—what they were going to keep and what they were going to throw out—

CHAIR: Senator McKenzie, can you rephrase it as a question, please.

Senator McKENZIE: and I cannot get a simple answer to a very simple question that actually goes to the heart—

CHAIR: Senator McKenzie, can you rephrase it as a question for the minister, please?

Senator McCarthy: I've said I'll take that on notice. Senator Mackenzie, I notice you get very excited about all of this. I wish you were—

Senator McKENZIE: Well, it's my people that actually can't get to a doctor.

CHAIR: Senator McKenzie, the minister is finishing her answer.

Senator McCarthy: What about First Nations people who also need assistance in this space?

Senator McKENZIE: No-one's arguing that, Senator McCarthy.

Senator McCarthy: Really, because—

Senator McKENZIE: No-one's arguing that.

CHAIR: Order! Senator McKenzie and Senator McCarthy, I have the call. I will suspend the committee if you do not allow me to take the call and allow me to manage this committee's work. You will let the minister finish. Senator McCarthy, you will let the senator ask her question. Senator McKenzie, you have the call.

Senator McKENZIE: Commissioner, you went in your remarks to the importance of facilities such as I've outlined. Are you aware if the Labor Party has cut those projects and commitments in this budget?

Prof. Stewart: I'm aware of ongoing funding for the university departments of rural health within the Rural Health Multidisciplinary Training program. I'm not aware of any reduction.

Prof. Murphy: We're not aware of any specifics; we're just following up. We will investigate. I'm not aware of any formal cuts in the budget to measures. We will find out.

Senator McKENZIE: It's cuts to facilities that were being committed to in the March budget, but facilities that were going to go to training of young people.

Prof. Murphy: We'll find out and come back to you.

Senator McKENZIE: I'd really appreciate it because I can't get a straight answer.

Ms Shakespeare: We may need to check with Infrastructure on that.

Senator McKENZIE: Yes, you probably will.

Ms Shakespeare: But we are unaware of health measures.

Senator McKENZIE: No, I appreciate that. But the commissioner was very clear that Health can do everything they can, but without actual facilities on the ground in rural and regional communities, we can't train country kids locally to practise locally.

Ms Shakespeare: There have been some additional investments through the recent budget to assist with the training of medical students.

Senator McKENZIE: Building facilities?

Ms Shakespeare: Yes. There's funding for a new medical campus for James Cook University in Cairns, which includes CSPs, which are the training places, but also capital and recurrent costs of supporting that as well.

Senator McKENZIE: Great. Thank you. I'd really appreciate that.

CHAIR: Does anyone else have questions for the National Rural Health Commissioner?

Senator RUSTON: No, I don't, but can I just put on the record the amazing work that Dr Stewart does and thank her very much for that work.

Senator McKENZIE: Chair, Senator Davey would like an update on how the Murrumbidgee employment model trial is going and whether it has been expanded to other regions.

Prof. Stewart: We often refer to it as the Murrumbidgee model. It's a single-employer model whereby the general practice trainees are employed by the Murrumbidgee local health district throughout their general practice training. That model enables the junior doctors in training to continue to access the leave entitlements such as maternity leave and sick leave, et cetera, and superannuation while they are in their general practice training, because it has been identified that, during general practice training, as a trainee moves from one practice to another, with each move they lose advantages. We are told by junior doctors that they take that into consideration when they're thinking about whether they want to become a general practitioner or another specialty. The Murrumbidgee model has commenced and is fully subscribed. That's about all I can tell you about it. I've spoken to some of the junior doctors who are employed within it and they're happy, but it's very early days, so we certainly don't have any outcome data. That will take some time. That will take the full four years to see exactly what happens with that—four years of general practice; sorry, rural generalist training, because the Murrumbidgee model is particularly designed around rural generalist training. That is a specialised field of general practice training specifically for rural practice.

Senator McKENZIE: Thank you. My understanding from Senator Davey is that Labor said they would expand this model to other regions. Has that occurred yet or has there been any consultation?

Prof. Stewart: There are a number of other sites around Australia that are investigating and in discussion as to how they would run a single-employer model. There are some that are actually being run but not using that terminology.

Ms Shakespeare: There was additional funding in the recent budget to support expansion of these trials, but I might turn to my colleague to talk about where those are at. We have got some extra ones underway now.

Mr Williams: I am happy to give you an update of the existing trial as well. So, as of now, there are seven participants on the single-employer model. That's across Wagga, Gundagai, Temora, Cootamundra, Deniliquin and Narrandera. We have a maximum capacity of 20 rural generalist trainees through this program. As the Rural Health Commissioner indicated, we have four years through which that program will be rolled out. We've got a second trial in the Riverland Mallee Coorong local health district in South Australia that is currently in development. As indicated as well, the current government has committed to an expansion of the models across Australia. It's currently in negotiation with the states and territories as to where those might happen. But it should be by January next year around where we can undertake applications and make assessments of where the next trials might be undertaken.

Senator McKENZIE: Commissioner, one of the issues when I was last in this area was the colleges. We were trying to make sure that colleges would prioritise rural and regional experience or practice as part of a requirement for certification. How's that going? I thought we only got two.

Prof. Stewart: I think if you came back into the area you would notice that there has been change. The specialist training program continues. Some of the colleges are very active in establishing rural training programs—not all, but there has been good deal of progress.

Senator McKENZIE: If you, on notice, could give me a naughty and nice list, that'd be great. Thank you.

National Health Funding Body

[11:50]

CHAIR: We will move to the National Health Funding Body.

Senator STEELE-JOHN: I think this question will probably go to the minister to kick us off. Are you aware that both the AMA and state health ministers have requested the federal government continue the fifty-fifty funding arrangement with state hospitals?

Senator McCarthy: I've certainly heard about it and I've certainly seen much of that in the news, but nothing to me directly.

Senator STEELE-JOHN: Has that been—I would assume that the health minister is aware of those requests.

Senator McCarthy: I wouldn't assume anything, but I'm definitely happy to take that to the health minister for you.

Prof. Murphy: I should say I think that is specifically referring to the COVID national partnership agreement, which is a fifty-fifty funded measure which terminates at the end of this year. The government has made no final decision on COVID response measures terminating at the end of this year. But there is still a process for government to look at those measures and see if any of them may or may not be extended in some form or another. I wouldn't say that there's been a firm decision of government about the COVID measures expiring at the end of this year.

Senator STEELE-JOHN: So, just to be specific, when you say the COVID measures, you're referring to—

Prof. Murphy: Well, there's a range of COVID measures expiring this year, but the national partnership agreement is the only agreement at the moment that has a fifty-fifty—

Senator STEELE-JOHN: In relation to hospital funding.

Prof. Murphy: Yes, in relation to COVID-related hospital funding.

Senator STEELE-JOHN: Yes.

Prof. Murphy: There is not a fifty-fifty split under the National Health Reform Agreement, as I'm sure Mr White can explain. That's a different split. But the fifty-fifty thing relates to COVID-related hospital expenditures.

Senator STEELE-JOHN: Which we still very much have. In this context, and just as we've sat here as a committee, Queensland's moved its COVID advice level to amber. We have had—I know the WA government and many state and territory health ministers have said very clearly to the federal government that they wish that funding to continue. I'm wondering why, Minister, when knowing just how vital this funding has been—particularly in places like WA, where just this week we've heard harrowing reports of over 20 deaths a year being caused by emergency wait times—the government is ending this arrangement on New Year's Eve.

Senator McCarthy: Thank you, Senator Steele-John, for your question. Just following on from Mr Murphy's response to you, we realise that, in terms of hospital funding, the NHRA is due to expire in 2025 and the ability to negotiate in preparation for that is going to take place as of next year. In terms of the process for us reaching an agreement, that is obviously going to start next year. In terms of your immediate response for what's going on in hospitals, I have no doubt that Minister Mark Butler is watching that very closely and working with the respective ministers of each state and territory.

Senator STEELE-JOHN: I would expect him to be. What he would see, as I said, in the WA context is a healthcare system—I think even to say that it is on the brink is probably understating it. As I said, the 2,000 deaths figure linked to emergency wait times is extraordinarily concerning to me.

Senator McCarthy: It is absolutely concerning and it should be to everyone.

Senator STEELE-JOHN: It is, absolutely. I'm sure it is similar in terms of the stress of the system in the Northern Territory and in many other healthcare systems as well. If I understand you correctly, what you have just said is that the partnership will cease and the government is seeking to negotiate a future broader agreement. Is there a time line for the conclusion of that negotiation?

Prof. Murphy: The NHRA goes to 2025. The government health ministers have agreed to bring forward a review—there's a mid-cycle review that was planned and that is going to be undertaken. That is to have a look at

some of those issues that might play into the next agreement. But the government's been pretty clear that the NHRA in its current form will serve its term until 2025. On the issue around the fifty-fifty funding, that's not in the NHRA. It never has been. That's specifically related to the COVID national partnership agreement. As I said, the government has not made any decision about COVID response funding beyond the end of this year. That's still a process under government consideration.

Senator STEELE-JOHN: So that's a process under government consideration. When will that consideration conclude? Do you have a very definite date for the end of that process?

Senator McCarthy: Can I just jump in. Obviously, this has been a problem that has been a long time coming. One of the critical themes that we placed in coming into government was the need to take the pressure off the hospitals. Obviously, with our strengthening Medicare and some of the other election commitments we've made, we are investing $235 million to commence the establishment of 50 Medicare urgent care units. So, Senator Steele-John, I guess my response here is, yes, we know there has to be the agreement and to look at the fifty-fifty that you're specifically asking about. But we also are doing and providing other measures in the health space to relieve the burden on hospitals.

Senator STEELE-JOHN: Well, we had, simply in WA alone, 2,000 deaths linked to wait times last year. That's just WA.

Senator McCarthy: Just in the last 12 months?

Senator STEELE-JOHN: Yes. If you took that across the nation, the figures I'm sure would be really shocking to the committee. Are you anticipating a reduction of services being required in hospital settings?

Prof. Kelly: If I may, just to be clear to the committee, that 2,000 number is based on an extrapolation of research-related matters. It's not an actual number. So I think we should be clear on that. There's no question that emergency departments are under pressure around the country and we've seen that for quite some time.

Senator STEELE-JOHN: Absolutely—there's no question.

Prof. Kelly: But I just caution on using that number as if it were a fact. It's not a fact. It is something that has been put forward by the emergency department doctors in that report based on research findings from other places. I just thought I'd point that out to the committee.

Senator STEELE-JOHN: They were very much known. Again, I would take you back, Minister: are you anticipating a reduction of services being required in hospital settings?

Senator McCarthy: No.

Senator STEELE-JOHN: So you're not anticipating a reduction of services being required in hospital settings?

Senator McCarthy: No, I'm not. Certainly, in line with my previous response, we're doing everything we can to assist the pressures on hospitals by improving other factors in the healthcare space.

Senator STEELE-JOHN: So you have decided to cut the funding of hospitals provided by the federal government on New Year's Eve, and yet you are not expecting a reduction in service needs?

Prof. Murphy: The core funding of hospitals, Senator, is not being cut.

Senator STEELE-JOHN: No, the end of the COVID partnership agreement will be a material reduction in the amount of money provided by the federal government to states and territories. That's just a fact.

Prof. Murphy: As I said, Senator, the government has not made any decision about COVID—

Senator STEELE-JOHN: Well, you can't decide to end it on New Year's Eve. That's when it ends.

Prof. Murphy: That's when it's currently terminating, but there has been no final decision about terminating COVID measures made as yet. There's still a process of government to consider those.

Senator STEELE-JOHN: Yes, but you have just said, Minister, that you do not anticipate that after New Year's Eve there will be a reduction in service demand. Yet your government has, at this point, committed to end that funding on New Year's Eve.

Senator McCarthy: I have committed to the fact that we are going to do a lot more to reduce the pressures on hospitals. That's been my response to you, Senator.

Senator STEELE-JOHN: Have you taken any steps—has the department taken any steps to model the impact of the ceasing of the COVID funding on elective surgeries that may have been pushed back?

Prof. Murphy: Senator, we have provided advice to government. The government is considering those measures terminating at the end of the year, and the government will make its decision in due course. But we've

provided advice on elective surgery and on all matters related to hospitals. I can't say any more than that. These government processes are still under consideration.

Senator STEELE-JOHN: How much do you expect the federal government's contribution to hospitals across the country will decrease by in 2023?

Prof. Murphy: The government's contribution to hospitals under the NHRA, as Mr White can say, is determined on the activity that is done by the states and territories. We have an agreement that has some caps and a funding formula. If they do the work, they get paid.

Senator STEELE-JOHN: Yes, but actually under the COVID measures—that's the line of questioning I'm pursuing with you. So, under the COVID measures, what's the decrease after?

Prof. Murphy: That's speculative, Senator, because, as I said, we haven't determined or government has not made a determination on what will happen with the COVID measures beyond the end of this year. We can go around this circle a bit more, but no firm decision has been made yet.

Senator STEELE-JOHN: I suppose my frustration, Minister, is that your government has made a clear commitment, stated in the budget papers, that this additional COVID funding will end on New Year's Eve. You may say to me that you haven't made a final determination about what will happen after that point. But, to healthcare workers working right now in emergency departments, they've got one set of certainty that money right now, which in some situations is helping them keep their heads above water, is ending and no certainty on what will come after in relation to that additional funding. You haven't been able to give me a time line as to whether and when they will have that certainty. Is there any time line for the conclusion of the government's consideration as to when and as to what the future of this additional COVID funding may be?

Prof. Murphy: That would go to the process of government. We can't divulge the process of cabinets and its committees. But I'm sure the minister—

Senator McCarthy: I would like to just clarify, though, that we have given you a time line, Senator Steele-John, in terms of the national partnership agreement. That is a time line I have provided to you. Certainly I take on board the concerns that you're raising, but I do reiterate what we are trying to do outside the areas of the hospitals in the meantime. Clearly this is a space that no doubt you'll keep following us up on.

Senator STEELE-JOHN: So you are cutting this funding. This funding ends on New Year's Eve. What do you expect people to do, Minister, on New Year's Day?

Prof. Murphy: Senator, I think I've said on a number of occasions that there is no certainty around—

Senator STEELE-JOHN: Professor Murphy, the reason—

Prof. Murphy: Can I just say one thing. The reason that government—

Senator STEELE-JOHN: That wasn't—

Prof. Murphy: delayed this decision was—

CHAIR: Excuse me, gentlemen. It does not help to speak over each other. Senator Steele-John, Professor Murphy is, I think, seeking to genuinely answer your question. Are you happy to let him proceed with his answer? I'll come back to you for a follow-up question to the minister if you require.

Prof. Murphy: I think I can just provide some clarity, Senator. The reason the government decided to make decisions whether or not to extend these measures later in the year was because government wanted to take into consideration the prevailing epidemiology later in the year. And, as you know now, we are in another small COVID wave. That will factor into those decisions of government and those decisions will, I believe, happen over coming weeks—certainly in enough time to provide notice to affected people. But we can't go into cabinet processes. I do think it's incorrect to say that all this COVID money will stop on New Year's Eve.

Senator McCarthy: Senator Steele-John, can I just remind you that this always was a temporary measure in terms of COVID. We do know it's going to expire on the 31st and we will continue working with the states and territories in terms of that funding.

Senator STEELE-JOHN: Just to follow up, what you described as a small COVID wave is having an impact right now in our community. The fourth wave of COVID-19 is here right now. Are you saying that there is the potential that this funding may be extended?

Prof. Murphy: I'm just saying that government has I think made it clear that these measures are under consideration before they expire. I can't speculate on what the decisions of government will be. Certainly, though, there is a process. It is a very deliberate process to look at the COVID response measures funded by the Commonwealth as closely as possible to the termination date so that we can get feedback from Professor Kelly

and the experts on what the public health situation is towards the end of the year. So there has been no final decision and we just have to await that process of government.

Senator STEELE-JOHN: So I'm hearing that Mr Murphy could suggest that—what I'm hearing from you is that Mr Murphy could provide evidence that would speak to the need and could provide epidemiological evidence to you and to the government—sorry, Professor Kelly—speaking to the need to extend the COVID arrangements. But what I've just heard from you, Minister, is that the measure was temporary. Are you saying that if the epidemiological evidence speaks to the need for an extension, it will be extended?

Senator McCarthy: Well, let's be clear. When all of this occurred at the time, it was temporary in relation to COVID. So let's be very clear on that, Senator Steele-John. But that is not to say—and as I've already outlined, with the health ministers meeting, in terms of Mark Butler meeting with states and territories and ongoing discussions, to add to Mr Murphy's comment about Professor Kelly, clearly if something eventuates in the meantime, I'm sure there will be a different direction.

Senator STEELE-JOHN: Okay. I, on behalf of the emergency workers of WA and of the entire country, really hope that very soon the government is able to provide them with more certainty than ongoing discussions. We'll let you know, because the stress level and the fear among that group and the extent to which they have burnt out is absolutely profound. And, as I said, they have one set of certainty that the funding arrangements for COVID will end on New Year's Eve and nothing beyond that currently.

CHAIR: Senator, can you direct it as a question, please.

Senator STEELE-JOHN: That's it. Thank you.

CHAIR: We will move to the Australian Health Practitioner Regulation Agency.

Senator RUSTON: Before we do, can I just ask for some clarification. I have questions in relation to health funding. I was thinking I would be directing them towards the department. They were along a similar line that Senator Steele-John was asking around the make-up to the funding arrangements between the states and the territories, both in terms of activity-based funding under the partnership and the COVID measures. Are they best directed to—

Prof. Murphy: If it's NHRA, I think it might be best for Mr White to be here for them, because he's the expert on NHRA and how it works. And the COVID response money does go through the funding body as well. So I think it might be worth him staying while you have your questions.

Senator RUSTON: Yes, sure. My questions were more around the two different lines of funding that exist in the budget—one in relation to the national partnership agreement on the hospitals, which is the activity-based funding, and also the funding that remains in place for 2022-23 in relation to COVID measures. In relation to the funding profile in the national reform agreement—there are so many different titles for things—the changes in the funding there show quite significant discrepancy, just depending on which state and territory. We've seen in New South Wales a $1.4 billion change in the profile over the four years of that funding to hospitals. I think it's $1 billion or $1.4 billion in Victoria. There's a heap in Western Australia, a decrease, and then we've seen other states and territories where that funding has increased. Now, I understand, obviously, that it's an activity-based model, as you pointed out, Professor Murphy, but I'm sort of interested to understand where the provision has been made in the budget, because the budget papers are very clear in a number of places that it is anticipated that there will be an increase in hospital service activity over the coming years. Where is the provision for that? Is it something that's in the Contingency Reserve? How has this budget accounted for the fact that there is a clear acceptance that there will be an increase in hospital services over coming years?

Ms Essex: The figures in the budget reflect the activity and the advice of the administrator as to the activity that the states have indicated that they will undertake. The funding formula, as Professor Murphy has indicated, is in the National Health Reform Agreement, and it's not a capped program, so that flows through in the budget each time the estimates are updated by the states and territories or when reconciliation happens. That happens at the end of the financial year. The budget figures and estimates are adjusted at that time.

Senator RUSTON: I certainly understand that. But what I'm seeking to understand is this. Clearly, we've had quite an anomaly in the last three years, to say the least—I'm sure, Professor Murphy, you've got different names for the COVID pandemic—that has clearly messed up the way our hospitals have had to operate and would clearly have messed up how activity is reported. So, I mean, everybody acknowledges that and I'm sure, Minister, that you'd be acknowledging that there has been a significant impact of COVID on how hospitals have operated. What I'm seeking to understand is that this isn't business as usual. We've got a situation where we've got massive deferred care, we've had no elective surgery and our hospitals have been operating in a completely different way for the last three years than they normally do. In the budget papers, it clearly states on a number of occasions that

there is no anticipated decrease in demand for hospital services. So I'm just asking what is the mechanism by which the Australian public, when they read the budget of this government—and you're obviously the funding authority for this budget—can know that has been provisioned for, despite the fact that you can sit here and tell me it's an estimate and there's variation. I get that. But the reality is we know it's going to be there, so why hasn't it been provisioned for?

Prof. Murphy: I think the budget papers show the funding going up every year. The challenge is the estimates variation for this year, which, as Ms Essex said, is based on the current estimates provided by the states and territories. Now, that's not the final position. The estimates are calculated by Treasury on the basis of what the states and territories say they think they will do. Some of those states are now revising those estimates and some of them they're not sure. They can code some activity under the COVID NPA and some under the NHRA and they're looking at the balance of that. So you've got to look at the holistic picture, because they are getting money under the COVID NPA at the moment. But, as Ms Essex said, no-one's cutting—there's no funding cut. If they do more activity—

Senator RUSTON: I didn't suggest that there was a funding cut.

Prof. Murphy: Yes, but, if they do the activity, the funding will be there and the estimates will be adjusted accordingly.

Senator RUSTON: But my point is, Professor Murphy, that we are living in extraordinary times. There is a mechanism by which I'm assuming that the states and territories have to report to you. They don't just pick a number out of the air; they will have a set of guidelines—well, I hope they do—that tells them how they have to report on this activity based funding. You know that activity based funding has been significantly distorted. We all know it's been significantly distorted. So where in this budget is the hospital funding that we know is going to be required for the hospitals?

Ms Essex: Senator, perhaps I could assist in just talking through a little bit—and Mr White, I'm sure, will assist me as needed—about how that funding is calculated.

Senator RUSTON: No, I know how the funding is calculated. I'm asking you: where in the budget is the provision, for a demand that you say is there, accounted for?

Ms Essex: Senator, if you look at the budget papers in 2024, 2025 and 2026, you'll see an increase in funding dollars in each of those years. The effect in the 2023-24 year is because of the reduced estimates in the base, which then flow through to each of the estimate years in the forward years. If the hospital activity for each state and territory increases, that funding will increase, because they are funded, as you've noted, on the basis of the activity that they undertake. And that activity based funding is based on a measure of the activity units that are colloquially called the NWAUs.

Senator RUSTON: Yes, I get all that. I'm just trying to understand. Every year, if you do an analysis of the national health reform funding from the budget in March and the budget in October, in some states and territories, every single year the funding goes down and, in totality, the funding goes down. Now, I understand why that's the case there. All I'm asking you for is to tell me where else in the budget—it won't be 2.4 billion. We're probably talking $5 billion in the sense that we're admitting that there's been no elective surgery and deferred care. I'm just seeking to understand where in the budget the funding to state and territory hospitals is contained, because it's clearly not going through the national health reform.

Prof. Murphy: Senator, it's a demand-driven program. Yes, if the activity increases, the estimates variation is based on the estimates at the moment, but the money will be provided if the activity is done. That's the way this works. The estimates variations are simply that—an estimate at the moment.

Senator McCarthy: And as Professor Murphy—

Senator RUSTON: Before you go on: Professor Murphy, I don't think I'm disagreeing with you that's the case. What I'm asking you is: if we are to have any faith that these budget papers actually represent the true position of expenditure on hospital service funding, you would like to think that there would be a provision in here in some way, shape or form. It may well be in the Contingency Reserve. I mean, that might be where it is. I don't really mind. But the narrative is there have been extraordinary circumstances. We know there's going to be a significant increase in demand for a whole heap of reasons in the need for hospital service funding, and it is not provisioned for in this budget at all. And you're just merely saying to me, 'Don't worry about that—it'll get fixed up later'. We need an accurate reflection of the finances of the government. That's the purpose of estimates. I'm seeking to understand whether this government has actively, because it has been able to through the mechanism of activity funding, completely ignored the potential for $2 billion, $3 billion, $4 billion or $5 billion over the

forward estimates not to be contained in this budget because they've chosen not to account for something that they have clearly stated is going to occur. That's all I'm asking.

Prof. Murphy: Senator, the Treasury are responsible for the estimates variation and the estimates formula and making or not making provisions. I think the Treasury officials have had their estimates but they'd be very happy to talk about the methodology they use for creating the estimates. But we provide the activity based estimates—the states and territories provide it. They then do the estimates variation and they construct those papers.

Senator RUSTON: Clearly we've got a significant underestimation here. I think that would be fair. Mr White, as the head of the funding authority, is it part of your role to understand from where we are sitting today what the likelihood of the additional funding variation in these estimates is likely to be over the forwards? Or is that not something that you do?

Mr White: The forward estimates modelling is the purview of the department. What I could offer over the last three years is activity estimates from the states based on the contracts that they sign between state governments and local hospital networks. And different states have projected different activity levels over those different financial years. Some have assumed things will go back to normal. Some have assumed a level of softness that would continue to occur. So those estimates in activity have increased and decreased depending on the particular state. We've certainly provided our best advice on where things are at based on what we were advised by the states and territories as a starting point for the forward estimates.

Senator RUSTON: Professor Murphy, have you provided advice to government—what you think the likelihood of the cost of that increased demand? Clearly you must have advised. You would have had input into the health component of this budget. In there, there is some very clear narrative around the fact that there isn't expected to be a significant increase in demand for hospital services going forward. Notwithstanding the reason why these figures are like they are, have you provided advice—

Prof. Murphy: We've certainly provided advice to government on public hospital activity. In Budget Paper No. 3 on page 17, I think it shows very clearly that the payments to support state health services increase each year over the forwards. So the budgeting does anticipate continued growth in public hospital funding over each of the years of the forwards.

Senator RUSTON: Does that increase in funding across the broader health payments to states and territories take into account the distortion that has occurred in the national health reform funding?

Senator McCarthy: As colleagues have explained, it takes into account the estimates that are provided by the states and territories, which are based on their best understanding of the future at a point in time. It takes into account the ons and offs, the ups and downs, which you characterise as distortions. But they are estimates and they will be reconciled over the course of the year to actuals.

Senator RUSTON: I'm not disagreeing around the accounting practices. I'm sure they're very standard. What I'm trying to understand, with your clever accounting hat on—do the figures that are represented in terms of the payments to support state health services as well as the national health reform funding arrangements collectively take into account the increases in hospital services that have been outlined as going to occur in these budget papers? Or is it remaining silent and are you waiting for an estimates variation to come in, which you think is likely to come in? Is it in these budget papers or isn't it? It's impossible to tell from reading this.

Senator McCarthy: I would expect there to be estimates variations in every fiscal update and—

Senator RUSTON: I know you've got to be careful about how you answer the question. But the reality is we know that between March and October there is $2.4 billion less in the hospital funding arrangements over a six-month period. Clearly every other indicator would suggest that there will be a continuing increase in demand on services. Is that $2.4 billion plus whatever increase is likely to occur over this period of time contained in any budget figures in this document? Or are you expecting that over the next four years there will be a $2.4 billion-plus additional cost to the Commonwealth because of increased hospital services?

Senator McCarthy: The figures as published obviously take into account that $2.4 billion which is spread over the forward years, so—

Senator RUSTON: Where would I find that?

Senator McCarthy: You'll find it in those bottom-line figures on page 17 and you'll also find it referenced in Budget Paper No. 1. I haven't got it with me, so I can't tell you exactly the page number, but it's in Budget Paper No. 1 where it lists the material estimates variations, the ups and downs. It's around page 95, give or take, from memory. That's where it talks about the $2.4 billion downward estimate.

Senator RUSTON: It's 94.

Senator McCarthy: Close. I'm not good with numbers, Senator!

CHAIR: Senator Ruston, can I ask you to wind up this block of questioning. We will of course, come back to you.

Senator RUSTON: I will be coming back to this. Mr McCormack and Professor Murphy are likely to be in place. I'm not sure whether we need to keep Mr White but I'll let the department and you decide whether they're—

Prof. Murphy: Unless there are specific questions under the NHRA funding, probably not. Mr White doesn't create the budget estimates. They're a creation of Treasury, the budget papers, and we work with them.

Senator RUSTON: I was going to go to the COVID funding.

CHAIR: We'll come to outcome 1 shortly. The committee agreed earlier to conclude with AHPRA before we proceeded with the remainder of AHPRA 1 and the remaining agencies. If that's still the committee's preference, we will continue with that and we will come to outcome 1—noting that we were meant to move to outcome 2 at 3.15. So could we have AHPRA to the table please. Mr White, you are welcome to leave. You are also welcome to stay. I feel I need to be clear to everyone now.

Australian Health Practitioner Regulation Agency

[12:27]

Senator ROBERTS: Thank you for being here today, especially Mr Fletcher. My questions go to who is responsible for a number of events in recent years. I note, Mr Fletcher, recommendations 9 and 11 of the April 2022 Senate Community Affairs References Committee inquiry into administration of the national scheme. Can AHPRA confirm whether the general practitioner registrar, Dr William Bay, is still indefinitely suspended under section 156, 'Immediate action powers'? He has been since 17 August 2022 for posing a serious risk, apparently, to the safety of the Australian public for questioning the safety and effectiveness of the COVID-19 vaccines.

Mr Fletcher: Senator, I'm going to be very careful about what I say about current matters, partly because there are very strict confidentiality requirements in the national law and also because I don't want to prejudice any ongoing investigations or inquiries we have. I will ask Dr Jamie Orchard to join me, the general counsel for AHPRA, and he can advise me on what we can say specifically about the practitioner you've raised.

Senator ROBERTS: Let me get on with the next question, then. It continues with Dr William Bay. Can you specify what risk this doctor still poses, despite him not being accused of any harm against patients or there being a single patient complaint lodged against him, especially in consideration of recommendation 9 of the recent Senate report that I referred to a minute ago, where the committee recommended that notifications accepted by AHPRA be limited to clinical cases relating to patient safety, and recommendation 11 to improve timeliness of resolving the notification process?

Mr Fletcher: Senator, the only thing I'm going to be able to tell you about that particular practitioner is what's on the public register. I won't be able to talk about the reasons behind that. I'm just needing to confirm his current status.

Senator ROBERTS: While you're looking for that, how many health practitioners, doctors, have had their registration suspended for questioning the safety or efficacy of the COVID-19 vaccines?

Dr Orchard: Senator, in respect of Dr Bay, he has been suspended. He has been suspended pursuant to section 156 of the national law. That's the immediate action power. He remains suspended at the moment.

Senator ROBERTS: Are you aware that he has not been accused of doing any harm against patients and he has not had a single patient complaint lodged against him? This is in light of recommendation 9:

The committee recommends that notifications accepted by AHPRA be limited to clinical issues relating to patient safety.

He's not done anything like that.

Mr Fletcher: Again, we're not able to comment about the reasons for immediate action—

Senator ROBERTS: Okay. Let's get on to question 4.

Mr Fletcher: Can I just make the point that suspension is an interim measure and it has to meet a threshold in terms of a risk to public safety or a public interest consideration. It is an appellable decision. So if a practitioner believes they have been treated unfairly in the decision-making of the board, they can appeal that to a tribunal.

Senator ROBERTS: What are the chances of that, given the complexity in what's been going on? How many health practitioners, doctors, have had their registration suspended for questioning the safety or efficacy of the COVID-19 vaccines?

Mr Fletcher: Senator, I did provide the data this morning but I'm happy to repeat that. There are 28 practitioners who have been subject to immediate action—as I say, the interim action we take while we investigate further. Of those 28, 11 were suspended in relation to conduct related to the spread of misinformation—for example, things like claiming that COVID-19 was fake, claiming that the vaccine program was government-led mind control. Ten were suspended in relation to things like failure to comply with public health orders, serious or at times fraudulent behaviour; also things like fake facts, administration, or indeed concerns about large-scale exemption certificates not consistent with the guidance from ATAGI. Seven practitioners have not been suspended but have had restrictions placed on their registration which cover things like requirements for additional supervision or limitations in relation to what they can do around issuing vaccination exemptions or their prescribing.

Senator ROBERTS: How many have been threatened or warned directly?

Mr Fletcher: What do you mean by threatened? We don't threaten or warn practitioners.

Senator ROBERTS: How many do you think have been affected by what's been going on with doctors and nurses from AHPRA?

Mr Fletcher: Again, going back to information I provided earlier, we have dealt with, in the financial year 2021-22, 1,303 notifications.

Senator ROBERTS: I'm talking about the doctors and nurses who are cowed into silence and will not speak up.

CHAIR: Senator Roberts, can I ask that you phrase this as a question for the officials to answer.

Senator ROBERTS: Okay, I'll move on. Can AHPRA specify exactly who they take direction from? I want to know who is responsible for what's going on. The Health Practitioner Regulation National Law Act 2009 states that AHPRA and the board's members are appointed by and its policies are set by the ministerial council. Who is responsible for AHPRA's decisions ultimately?

Mr Fletcher: The ministerial council comprises all of the state and territory health ministers and the Commonwealth health minister. They have certain accountabilities under the national law. Among other things, they appoint members of the AHPRA board and they also appoint members of the 15 national health practitioner boards.

Senator ROBERTS: I understand Yvette D'Ath is the chair of the Health Ministers Meeting and Brad Hazzard is the secretariat. What role does federal health minister Mark Butler play in this oversight?

Mr Fletcher: Minister D'Ath is the chair for the Health Ministers Meeting. Brad Hazzard is actually the New South Wales health minister. The Commonwealth health minister is a member of the ministerial council.

Senator ROBERTS: So no special role?

Mr Fletcher: He is a member of the ministerial council.

Senator ROBERTS: You've been head of AHPRA since its inception in 2011. What role do you play?

Mr Fletcher: I'm the CEO of AHPRA, so I'm responsible to the corporate board of AHPRA for the work of AHPRA as the administrative arm of the National Registration and Accreditation Scheme. I think it's important to clarify, Senator, that AHPRA is not the regulatory decision-maker in relation to, for example, notifications about health practitioners. Those are decisions of national boards, again appointed by the ministerial council and comprising both practitioner members from the profession and community members.

Senator ROBERTS: Let's come back to that. What directions have been provided to AHPRA by the Health Ministers Meeting to date and by the guilds, the boards, the medical profession?

Mr Fletcher: Under the national law, the ministerial council has the ability to issue a policy direction to the boards and to AHPRA. It can't be about an individual practitioner. It has to be about a policy issued. There have been four policy directions in the life of the national scheme. One related to the financial arrangements for the co-regulatory arrangements in New South Wales. That was back in 2010. We've had one in relation to the outcome of the accreditation systems review that was commissioned several years ago. And there have been two that relate to what has now become amendments to our national law, essentially around the primacy of patient safety in the work of the scheme and the regulatory decision-making of boards.

Senator ROBERTS: What is the relationship between AHPRA and yourself with the, AHPPC, the Australian Health Protection Principal Committee, which I understand Professor Kelly chairs?

Mr Fletcher: AHPRA has no direct relationship with that.

Senator ROBERTS: Can AHPRA please detail all sources of revenue it receives and whether any of these sources of revenue are from pharmaceutical corporations or international lobbyists, including the US-based Federation of State Medical Boards or the International Association of Medical Regulatory Authorities?

Mr Fletcher: Senator, our funding is predominantly from the registration fees that each of the health practitioners pays on an annual basis. We receive no funding from pharmaceutical companies and we've received no funding from the FSMB in the USA, or the—

Senator ROBERTS: AHPRA's COVID position statement, dated 9 March 2021, essentially tells doctors that the government's public health messaging is more important even where it conflicts with scientific evidence, informed consent, the primacy of the doctor-patient relationship, and the health and wellbeing of medically contraindicated Australians. If a doctor comes to the view that public health messaging is in conflict with evidence-based medicine, should they follow AHPRA's statement, or their own code of conduct?

Mr Fletcher: Senator, the joint position statement on COVID-19 which we released in March 2021 is in fact not a statement from AHPRA. It is a statement from all of the 15 national boards supported by AHPRA. And as I said earlier, those boards comprise both practitioner and community members. At the time, it was a response to queries that we were getting about practitioner obligations in relation to COVID-19 vaccination. That was a time when we were seeing, for example, mandatory requirements for healthcare professionals working in health care to be vaccinated. The statement essentially aims to make clear how national boards apply existing regulatory frameworks in the context of COVID-19. So it's important to note that many of the obligations in that statement are not new obligations; they predate the pandemic and they are actually reflected in the codes of conduct which all of the national boards have for the professions they regulate. At the core of it is an expectation, which I think reflects the expectation of the community, that health practitioners use both their professional judgement and the best available evidence in practice, including when they are on social media. I think it's important to also note that the statement also recognises that some practitioners may have a conscientious objection to vaccination. Again, that reflects provisions in the codes of conduct. And it sets out clearly what a practitioner needs to do in terms of telling their employer; complying with any of the relevant, at the time, public health directions and laws; and also ensuring that their patients and consumers have referral options.

Senator ROBERTS: Have you seen the open letter to AHPRA from Australian allied health practitioners, nurses, midwives and doctors?

Mr Fletcher: I've probably had several letters from them, Senator. I don't know if you're referring to a specific piece of correspondence.

Senator ROBERTS: I don't have a date on this one. But they are basically saying that you are doing this, AHPRA is doing this. So how could they be so confused?

CHAIR: It may assist if that could be tabled to enable the officials to—

Senator ROBERTS: I'll bring it back after the break. It's got notes on it.

CHAIR: Could you bring it back after Senator Ruston's questions? It is the committee's intention to dismiss AHPRA.

Senator ROBERTS: I'll resume with that.

Senator RUSTON: Following on from Senator Roberts, who ultimately is AHPRA responsible to?

Mr Fletcher: Are you talking about AHPRA the organisation? There are a lot of moving parts.

Senator RUSTON: Well, you.

Mr Fletcher: I'm responsible to the board of directors of AHPRA. So they could fire me if they chose to; they could hire a new CEO if they chose to. That board of directors is appointed by all of the health ministers. But the work of the scheme more widely has certain accountabilities to the ministerial council. I can give you one example. If a national board is setting a registration standard which sets out the requirements for registration in a certain profession, then ultimately that has to be approved by the ministerial council.

Senator RUSTON: If you want to do anything outside of the agreement of your corporate plan, how would you go about seeking to make a change to your activity?

Mr Fletcher: Do you mean, just to clarify, in terms of our remit within our law? Obviously the first point would be: is it lawful in terms of what our national law allows us to do? The national law is a reference—

Senator RUSTON: I'm hoping that you're always acting within the law, although some of my colleagues might argue otherwise. I'll give you an example. What would happen if there were a suspected misconduct within

AHPRA? Let's be really mean. What would happen if there was an allegation of misconduct against you? What would happen there?

Mr Fletcher: If there was an allegation of misconduct against me, that would obviously be something for the board of directors of AHPRA, the AHPRA board, to decide how they would want to deal with that. It may well be that they commission an independent investigation of that. If it came as a public interest disclosure, it would be dealt with under our public interest disclosure arrangements. And I would also note that we have an independent ombudsman for the work of AHPRA and the boards, the National Health Practitioner Ombudsman and National Health Practitioner Privacy Commissioner. Although she wouldn't look at employment issues per se, she would certainly look at any concerns that were being raised about the way that we were implementing the requirements of the national law from a process point of view.

Senator RUSTON: In terms of the department's relationship with AHPRA, if you were concerned, as the federal department of health, around some regulatory aspect of the health system, what is your ability to interface with AHPRA?

Prof. Murphy: We have a very close working relationship with AHPRA. For example, my department is working very closely with AHPRA around the cosmetic surgery issue at the moment. But ultimately if we wanted to set AHPRA on a different course—cosmetic surgery is a good example—

Senator RUSTON: We're going to that in a minute.

Prof. Murphy: then, through Minister Butler, we would go to the ministerial council and say, 'We think that AHPRA needs to do more work around regulation of cosmetic surgery.' The ministerial council would then instruct AHPRA to do that work. So ultimately the ministerial council is the body. But at a practical level we work very closely with AHPRA on a range of matters. Again, the other good example at the moment is the issue we talked about earlier about migration and processes for registering overseas-trained doctors. Ms Shakespeare, do you want to add anything more?

Ms Shakespeare: No, I think you've covered that.

Senator RUSTON: Would the department ever investigate the actions of AHPRA?

Prof. Murphy: If we had serious concerns. Obviously if someone came to me and accused Mr Fletcher of impropriety, we would take that very seriously. I would probably go to the board of AHPRA and investigate. But we generally have been pretty comfortable with AHPRA. We are certainly very keen to look at some of these regulatory processes around overseas-trained health professionals at the moment. And ministers have been, I think, particularly concerned about cosmetic surgery and they have been driving a reform agenda there. And AHPRA is very responsive to the direction of the ministerial council because ultimately they're the boss.

Senator RUSTON: Have you undertaken any investigations into AHPRA recently?

Prof. Murphy: No, not that I'm aware of.

Ms Shakespeare: The Commonwealth department of health would not initiate or conduct investigations relating to AHPRA. AHPRA is established under state and territory legislation.

Senator RUSTON: That's in direct conflict with what—

Ms Shakespeare: We would raise, as Dr Murphy said, concerns through the ministerial council.

Senator RUSTON: You said—

Prof. Murphy: We wouldn't directly do it, no. I said if an allegation came we would take it to the right level.

Senator RUSTON: Do you receive any money outside of your registration fees?

Mr Fletcher: As I said, the main source of income is registration fees. There are also fees for renewal. There are also application fees. Sometimes we do get costs awarded in relation to actions that we take in tribunals. And we did receive some targeted funding through the Commonwealth department of health in relation to some surge workforce initiatives during the height of the COVID-19 pandemic.

Senator RUSTON: So the only funding that you've received from the Commonwealth or from the states and territories has been related to particular project work?

Mr Fletcher: That's correct, yes.

Senator RUSTON: Moving on to cosmetic surgery, the simple question is, Mr Fletcher: do you believe that there is a public expectation that when somebody is going to have invasive surgery the person who is purporting to be the surgeon should have surgical training in excess of the MBBS?

CHAIR: Senator, can I confirm you're not asking for Mr Fletcher's opinion; you're asking for policy—

Senator RUSTON: He is the regulator and he has to regulate this sector. I'm not asking for his personal opinion.

CHAIR: Senator Ruston, could I ask you to rephrase it to assist the committee, given we are not to ask officials their own opinions. Could you rephrase it, please.

Senator RUSTON: Mr Fletcher, do you have any evidence to suggest that there is a public expectation that somebody who is undertaking invasive surgery would have a qualification in surgery in excess of an MBBS qualification?

Mr Fletcher: Senator, what I could comment on is the fact that the independent review that we commissioned clearly showed that there was a lot of confusion for the community about the education and qualifications or training of people who were offering cosmetic surgery services. The review has actually recommended the development of an area of practice endorsement on registration, which would set minimum standards and training requirements, which would then allow a practitioner to have an endorsement on their registration indicating that they've met a certain requirement around education and training to undertake cosmetic surgery. I also note that health ministers collectively have agreed to protect the title 'surgeon' as well. So that will become a protected title in the national law. We think all of those things are very helpful measures, because what's very clear when you look at the cosmetic surgery industry is that there is significant information asymmetry for consumers. The more that we can help people make safe choices about the practitioners they see, I think the better it is going to be for the community.

Senator RUSTON: The independent review into the Australian cosmetic industry, I note, doesn't use the word surgery. It says it's an independent review into the Australian cosmetic industry. Yet one of the recommendations of that review was that we have a cosmetic surgery enforcement unit. I know it's a detail around the nomenclature here, but the review was silent on—it makes no recommendations in regard to the term cosmetic surgery, does it?

Mr Fletcher: The review wasn't a review of the cosmetic surgery industry widely. It was specifically looking at the question of medical practitioners who undertake cosmetic surgery and what needed to be done to improve the safety of those services for the community. The cosmetic surgery enforcement unit which we've established within AHPRA was one of our major responses to the recommendation of the review. At the time of the review, the review was aware that ministers—there was a consultation occurring about the question of protecting the title 'surgeon'. So the review didn't look at that specifically because that was a different process being led through government. But it ultimately made the recommendation about creating the area of practice endorsement, which would be an Australian Medical Council accredited requirement. We've accepted that recommendation and we're working with the AMC to get that endorsement in place.

Senator RUSTON: Is the Australian College of Cosmetic Surgery and Medicine accredited by AMC?

Mr Fletcher: Not to my knowledge, no.

Senator RUSTON: You don't think you should know that?

Mr Fletcher: It's not. It's not an AMC-registered specialisation.

CHAIR: Senator Ruston, do you have a few more in this block? Or I'll return to you.

Senator RUSTON: I've got a ton more on this, so if you want to share it around—

Senator ROBERTS: I've tabled a copy of that letter, the wording of it. AHPRA's position statement dated 9 March 2021 essentially tells doctors, Mr Fletcher, that the government's public health messaging is more important, even where it conflicts with scientific evidence, informed consent, the primacy of the doctor-patient relationship, and the health and wellbeing of medically contraindicated Australians. If a doctor comes to the view that public health messaging is in conflict with evidence-based medicine, should they follow AHPRA's statement, or their code of conduct?

Mr Fletcher: Again, Senator, just to clarify, this is a statement across all of the 15 national boards for each of the regulated health professions supported by AHPRA. What the statement says is that health practitioners should use their professional judgement and the best available evidence in their practice, and that is entirely consistent with the obligation on registered health practitioners that was in place prior to the pandemic. If concerns were being raised about how a health practitioner had exercised their professional judgement, we would—we are required to assess those concerns but we assess each of those concerns on its merits. We would certainly look to the public health advice of each of the state and territory jurisdictions in the Commonwealth. We would look to ATAGI; we would look to TGA—

Senator ROBERTS: The question was: if he comes to the view or she comes to the view that the public health messaging is in conflict with evidence-based medicine, should they follow AHPRA's statement or the doctors code of conduct? That is the question.

Mr Fletcher: If a practitioner was brought to our attention as someone where there was concern about what they were doing, as I say, we would look to those established forms of advice. And we would also give the practitioner an opportunity to explain from what sources they've drawn the evidence that they've based their clinical decision-making on before any decision is made about whether regulatory action is needed.

Senator ROBERTS: Maybe this is why you're not answering my question that I've asked now twice. This is a legal opinion that we've obtained: 'As statutory rules, the codes of conduct for each health profession always prevailed over the 9 March statement from AHPRA, where practitioners were always legally required to observe their code of conduct first and despite the AHPRA statement. Wherever there was inconsistency between the AHPRA statement and the codes of conduct, then the codes of conduct prevailed and the inconsistent portions of the AHPRA statement were truly invalid and nugatory at law. AHPRA never had any legal basis for those portions of the statement that were inconsistent with the codes of conduct. Where AHPRA's threats and intimidation were inconsistent with the paramount guiding principle of the national law, being section 38, the health and safety of the public are paramount.'

Senator URQUHART: Chair, can I ask a question on that? Senator Roberts, you said you had a legal opinion. Do you have a source? Where's it from? I'm sorry if I missed that earlier.

Senator ROBERTS: No, I didn't tell you where it's from. It's from a barrister who's been working with a group of lawyers.

Senator URQUHART: But we have nothing in front of us to show where it's from.

Senator ROBERTS: I'm just reading out a legal opinion. That tells me you're encouraging doctors to breach their code of conduct.

Mr Fletcher: Senator, I might ask Dr Orchard to respond to that.

CHAIR: We're reading from documents. It probably would assist the committee members to have a copy of those documents if they're things you're prepared to table. I appreciate you're seeking to table this. The committee will make a decision on that at some point in time. Ultimately it's up to witnesses if you choose to answer. If it assists, it might be something you look to do, Senator Roberts.

Senator ROBERTS: The question is a simple one. Which prevails: AHPRA's order, the gag order of 9 March, or the doctors code of conduct? That's all I need to know. That's all doctors need to know.

Dr Orchard: Senator, the 9 March statement specifically refers back to the code of conduct and gives it primacy. So if there was any concern about the conduct of a practitioner, it would be by reference back to the code of conduct, as opposed to the position statement. The position statement explains how practitioners might conduct themselves in order to comply with the requirements of the code of conduct.

Senator ROBERTS: Why is it, then, that so many doctors and nurses are terrified of speaking out? Others have resigned from their professions after 30 or 40 years because they're afraid that AHPRA will get them. Why? What have you done, Mr Fletcher, or what has AHPRA done to put that fear into doctors of not giving the best advice in their own professional medical opinion?

CHAIR: Senator Roberts, your questions are bordering on asking for an opinion. I'll let the officials answer it. But I remind committee members that we aren't to ask officers for their opinions. You can ask them questions relating to policy, relating to expenditure, relating to portfolios.

Mr Fletcher: Senator, I can only repeat what I've already said: the statement, which is consistent with obligations in the code of conduct, essentially requires health practitioners to use their professional judgement and best available evidence in practice. Practitioners who are doing that have nothing to fear from AHPRA. And even those who are brought to our attention where there's a concern will always have an opportunity to explain the basis on which they've made their decision, and that will be taken into account in deciding whether any regulatory action is needed.

Senator ROBERTS: There are many, many doctors who are terrified of you guys. Let me go on to—

CHAIR: Senator Roberts, please, if you could—

Senator ROBERTS: It's a fact.

CHAIR: This is not a forum for debate; it is a forum to ask questions and a forum to hear answers. So I ask you with respect, Senator Roberts, to pose these as questions to the witnesses.

Senator ROBERTS: I would like your confirmation or otherwise of some of these statements, please. You were with AHPRA from the start, 2011, Mr Fletcher. Matters on the health front shifted up several years with the coming into force of the Commonwealth National Health Security Act 2007. The National Health Security Act has delivered the Commonwealth government extensive new powers—states prior to that had the power over health—and authority over national health policy by essentially establishing a fourth tier of government composed of the leaders of the states and territories and the federal government, specifically with the Commonwealth Chief Medical Officer as the head of Australian Health Protection Principal Committee and the Prime Minister as head of the National Cabinet. Is that correct?

Prof. Murphy: That's not really a question for Mr Fletcher, Senator, with respect. Professor Kelly is chair of the AHPPC, and we can talk about biosecurity and that stuff, but that's not relevant to our—

Senator ROBERTS: Minister, could I put on notice the question to you, please?

Senator McCarthy: Could you repeat the question so we can make sure we get what you want?

Senator ROBERTS: Sure. Matters on the health front shifted up several gears with the coming into force of the National Health Security Act from the Commonwealth in 2007. The National Health Security Act has delivered the Commonwealth government extensive new powers and authority over national health policy by essentially establishing a fourth tier of government composed of the leaders of the states and territories and the federal government, specifically with the Commonwealth Chief Medical Officer as the head of the Australian Health Protection Principal Committee and the Prime Minister as the head of the National Cabinet. I'd like that confirmed or otherwise.

Prof. Kelly: I can answer that question, Senator. None of those arrangements that you just mentioned are under the National Health Security Act.

Senator ROBERTS: Okay, thank you. By entering into a treaty in 2007 with the World Health Organization, commonly referred to as the WHO—the name of the treaty is simply the International Health Regulations 2005; is that correct?

Prof. Kelly: There was an instrument of the World Health Organization called the International Health Regulations 2005, to which Australia is a signatory. I'm not really qualified to state whether that was a treaty or not, but I could take that on notice.

Senator ROBERTS: Thank you. And, to be clear, the International Health Regulations are World Health Organization regulations. The WHO is a body that receives most of its funding from private sector groups, most of whom have extraordinarily deep connections and investments in big pharmaceutical companies. Is that correct?

Prof. Kelly: I would have to take on notice the funding of the World Health Organization. There are others perhaps in the room who can—

Prof. Murphy: We'd have to provide details, but the WHO receives a large amount of government funding. It does get some money from philanthropic organisations such as the Gates Foundation—

Senator ROBERTS: With connections to big pharma companies.

Prof. Murphy: Well, connections—it doesn't receive, to the best of my knowledge, direct income from big pharma, Senator, no. We can take it on notice and provide you a statement of the WHO funding.

Senator ROBERTS: Thank you. How do you listen to doctors? And are you aware, Mr Fletcher, that many are leaving the profession? Young doctors, the future of the medical profession, have had enough of AHPRA. That's what they're telling me, and they're leaving.

Mr Fletcher: I'm sorry to hear that you're getting that feedback, Senator, but our data would show that we are not seeing any significant trends in terms of medical practitioners leaving registration—for example, choosing not to renew their registration or moving from a practising to a non-practising form of registration. In fact year on year we have seen an increase in the number of registered medical practitioners in Australia. Indeed, across all of the registered professions we've seen an increase. We do routinely survey medical practitioners and other health practitioners who are subject to our regulatory processes. We certainly look very closely at that feedback and seek to make improvements to our processes, because we recognise that, particularly when you're subject to a notification, it can be extraordinarily stressful for a practitioner, so we want to do everything we can to make sure that we minimise that stress wherever possible, whilst obviously maintaining our core focus on public and patient safety.

Senator ROBERTS: Thank you for that. Who would be the one person responsible for what AHPRA has been doing? Would it be you as the CEO?

Mr Fletcher: I have certain responsibilities as the CEO. The board have certain responsibilities. Each of the 15 national boards have responsibilities in terms of regulatory policies and standards, and likewise the ministerial council has certain responsibilities. I'm very happy to provide information that sets out those accountabilities, because they are clearly set out, if that would be helpful.

Senator ROBERTS: So who would oversee the gag order that went out—what doctors are referring to as the gag order of 9 March 2022.

Mr Fletcher: Senator, it wasn't a gag order. I don't accept that characterisation.

Senator ROBERTS: I said doctors are referring to it as a gag order.

Mr Fletcher: That joint position statement was supported by all of the 15 national boards of each of the regulated professions.

Senator ROBERTS: Could we have the names of the heads of those, please?

Mr Fletcher: Certainly.

Senator ROBERTS: Thank you.

Senator REYNOLDS: Good afternoon. My first questions relate to an inquiry that you'd be aware that the parliament did in 2018 into transvaginal urogynaecological mesh. Certainly the secretary will be aware of that inquiry.

Prof. Murphy: Professor Skerritt is online from Dublin. He is probably the person to—

Senator REYNOLDS: I've got questions for both but I will start with AHPRA. You're aware of the issue surrounding this mesh—is that right?

Mr Fletcher: In general terms, yes.

Senator REYNOLDS: As I understand it, for those who don't know, there's transvaginal mesh and there are also vaginal tape implants, which I understand are pretty much the same. Professor Skerritt, have I got that right?

Dr Skerritt: There are different devices used. The ones that were of greatest concern were those that were applied transvaginally. There are other means of applying tapes and measures for gynaecological repair, especially when there's pelvic prolapse.

Senator REYNOLDS: The report by the committee—I'll come back to where we're up to with the outcomes—said the time line started in 1996, when the first urogynaecological measures were approved for supply in the US, and then in 1998 they were approved here in Australia. Then there's a long time line and a quite often sad history of what's happened to many women. But I want to go back before that. It has come to my attention that, in fact, trials on women appear to have been happening in Australia as early as 1988. This is a question for AHPRA. Are you aware of a Dr Peter Petros? Has that name come across your radar before?

Mr Fletcher: I'm not in a position to comment about individual practitioners beyond what's on our national register or—

Senator REYNOLDS: Okay. I might actually ask you a question on notice up front. If you can come back with as much information—because I've let my fingers do the walking to Google, and he is prolific in terms of claiming to have been the inventor of the tape and also had IP for it and has clearly made a lot of money on that, and mesh, over the years. But he's also been deregistered. He's also been subject to numerous successful malpractice claims. I see Dr Skerritt is nodding vigorously. I want to draw your attention to some quotes from Dr Petros that I ask you to take on notice and look into. Dr Petros said that he conducted animal studies at Royal Perth Hospital in 1987. Thirteen dogs had Mersilene vaginal tape implanted and then removed after six weeks. And he reported that 10 out of the 13 dogs developed tummy sinuses but the dogs' white blood cell count remained normal and they didn't develop a fever. And he went on to other things that I can't pronounce. So he clearly did animal studies on his tape in 1987.

Then he talks about how he did his first human studies in 1988 to 1989 on 30 women with stress incontinence. He didn't name the hospital, but my understanding is that it was a hospital in Perth's northern suburbs. He said that women were given the prototype TVT, which was his proprietary tape, instead of the Mersilene tape that he trialled on dogs. At the end of the six weeks, he made a number of reports about what actually happened, and he made no mention of physical or mental impacts of the women more than two weeks after. I've had anecdotal advice from people in Perth who were at the hospital at the time that in fact, many of these women suffered significant disabilities and permanent impacts from that. That would tend to indicate that here in Australia, work on this type of mesh and remedies for women with this particular problem started much earlier than when it was approved in 1998 by the TGA. That's the background to this.

I will come back to AHPRA. For animal studies—obviously there are different regulatory requirements about conducting studies. I'm not asking for an opinion now but I want to ask this on notice. Then going into human studies on women—even in 1989, what would have been the requirements for a surgeon to conduct a clinical trial in these circumstances?

Prof. Murphy: Senator, I might be able to answer that. It's probably a question for the department rather than AHPRA. Whilst a registered medical practitioner who does undertake research misconduct could be subject to regulatory intervention from AHPRA, the regulation of human research is a very different issue, and we've got officials here who are involved in that space. But essentially to do a human research trial like that, you would need the approval of a human research ethics committee and presumably the relevant hospital in Perth if this were—I'm not across this material at all but I'm talking hypothetically here. You would need a human research ethics committee approval, and that committee would require a lot of information, including the results of the animal studies. If there were in a research study to be misreporting or underreporting of adverse events, that's very serious research misconduct, and that misconduct would primarily be dealt with in the local hospital by the governance structure of that hospital. And, as I said, if it's a registered health practitioner, it may play into their registration status. But essentially, if you've got concerns about the way human research was done, you can direct it to the department on notice and we can undertake inquiries with the Western Australian authorities.

Senator REYNOLDS: I will do that, thank you, Professor Murphy. My understanding is that there was no ethics approval process whatsoever and that the women were discharged and their complaints ignored. The doctor concerned moved on and nothing else happened. So if you can take that on notice, I'll provide whatever information I can.

Prof. Murphy: We can take that up with the WA health authorities, who would be the relevant—

Mr Fletcher: My colleague has just checked. In fact Dr Petros's registration was cancelled by the New South Wales tribunal in 2019 with a finding of professional misconduct, and he is not currently a registered medical practitioner. We can certainly share with you the tribunal decision, which is in the public domain.

Senator REYNOLDS: Thank you; that would be very helpful. I understand there have been actions against him in other states, including in my home state of Western Australia and possibly Queensland.

Dr Skerritt: Again, we have to be careful to make sure we only release findings in the public domain, but there have been some other legal and administrative appeals tribunals issues relating to those products, and we're happy to share what we have in the public domain. This often covers several states.

Mr Fletcher: The deregistration is Australia wide; it's not just New South Wales.

Senator REYNOLDS: Thank you very much. I will leave that on notice with the three of you and I'll provide what other information I have. If you could come back and provide further advice—

Prof. Murphy: It will require the cooperation of WA Health to investigate.

Senator REYNOLDS: Yes. But if you don't get that, then that's something we can pursue separately. Thank you. The second one that I want to come to is Lyme disease, or tick-borne bites or Lyme-like disease as it's variously called.

Prof. Murphy: The term I think we're still using is debilitating symptom complexes attributable to ticks—DSCATT.

Senator REYNOLDS: Or medically unexplained symptoms as well—so there are many and varied terminologies for this. From the department's perspective, Professor Murphy, are you on notice able to provide an update on the implementation of the recommendations from our 2018 report, the second report—where that's up to? That's the first thing. And could you also answer: when people go to their doctors with a tick bite, under the MBS, what schedule can that be treated under?

Prof. Murphy: I imagine it would be treated under a general consultation MBS item. There'd be no specific item, I think, for a tick bite, unless there was some particular intervention. But let's take that on notice.

Senator REYNOLDS: If you could, thank you, for all various manifestations of that—terminologies.

Prof. Murphy: Professor Kelly has got carriage of this disease. I passed it over to him two years ago. He would be happy to answer that on notice.

Senator REYNOLDS: And I think 'medically unexplained symptoms' is a categorisation, so could you include that as well?

Prof. Murphy: There's a broad church there. Obviously a subset of that is the tick bite associated symptom complexes, but there are a range of others as well. We'll certainly respond on notice.

Prof. Kelly: I can answer some of those questions now, Senator. Thank you for handing that over to me, Professor Murphy. DSCATT is what we're using: debilitating symptom complexes attributable to ticks. We've had a lot of work, as you know, including the inquiry in 2018, and very good engagement with various peak bodies that are interested in this particular matter. In terms of funding of research, $8 million has been allocated for research into this issue since 2018. That included a one-off $200,000 grant to the Lyme Disease Association of Australia in 2019. And there's continuing work that's been associated with that. In relation to the actual inquiry of this committee, recommendation 1 has been completed. I won't go into the details but I'm happy to do that—

Senator REYNOLDS: On notice, that would be great, thanks.

Prof. Kelly: Recommendation 2 is progressing. That was in relation to the research, as I mentioned. The guidelines and so forth have also been completed. Maybe it is best for me just to table the update of all of the recommendations. But essentially almost all have been completed and the ones that are progressing are, in my view, progressing well.

Senator REYNOLDS: Thank you. Have you got the figures available on how many Australian patients have been referred to infectious disease specialists with potential tick-borne diseases from 2016 to 2022?

Prof. Kelly: I'm not sure that we'd be able to have that information, but I'm certainly happy to look at it and provide something on notice.

Senator REYNOLDS: Thank you. I don't know whether it's DSCATT or MUS but in terms of better care and Australia's healthcare plan 2022-2032, in section 3—this is one for notice—detailing the foundations of reform, my advice is that this is not sufficiently addressed. So could you come back about how MUS and DSCATT are actually now treated and the planning?

Prof. Kelly: Certainly, Senator. The other issue, which you haven't mentioned but I'm sure we will get to later in the hearings, is long COVID. There is a lot of overlap in many of the symptoms and issues that people are suffering from at the moment, with different names. The two you've mentioned and long COVID I think would be—chronic fatigue syndrome, all of those things. There's a lot of similarity there. One of the key similarities is the difficulty of diagnosis. I specifically and the department in general do recognise that these are real issues for real people. There was some media coverage of a recent press conference that suggested I did not believe in it. That is not true. I do know that all of those things are issues for real people and causing real suffering. The current parliamentary inquiry in the House of Representatives into long COVID will no doubt assist us in some of those issues, particularly teasing out where there are differences but also, probably more importantly, where there are similarities.

Senator REYNOLDS: That's very good. Thank you, Professor Kelly. I've got a lot of questions but I'll just put them on notice and if we could come back—but here is one for AHPRA: are you aware of the complaints that have been made over the years, including in two community affairs reports, about the conduct of doctors in relation to how they treat patients who attend thinking they've got Lyme disease or Lyme-like disease or a DSCATT bite? Has that come across your radar in the past?

Mr Fletcher: Yes, it has.

Senator REYNOLDS: On notice, could you report back to the committee about the types of complaints and the types of conduct that have come to your attention, and any guidance you may have issued to doctors, either infectious specialists or GPs? If you could provide the sum total in relation to Lyme that you're able to, that would be much appreciated.

Senator RUSTON: Going back to the cosmetic surgery inquiry recommendations and the like, in September, Minister Butler announced that the Medical Board would be embarking on a process of endorsement around the credentialling of medical surgery by adding an area of practice or in terms of endorsement on a medical qualification. What was the rationale behind doing that? I would have thought there clearly exists a pathway for specialist plastic surgeons. I mean, they have an accredited college. So I'm interested to understand the rationale behind coming up with an endorsement on a base qualification to enable somebody to undertake an activity that wouldn't normally be accredited under a different mechanism.

Mr Fletcher: Senator, the area of practice endorsement was actually a recommendation of the independent review. So essentially the Medical Board has agreed to act on that recommendation. And essentially an area of practice endorsement is really a regulatory tool. The reason why the review recommended that this was needed was because of the absence of any minimum qualifications or training requirements in relation to medical practitioners who are undertaking cosmetic surgery. So the endorsement is a means by which those standards could be set. It's done through the Australian Medical Council, so they're independently verified, if you like, and accepted by the Medical Board of Australia, and then they would appear on the public register. So a consumer

who was thinking about undertaking cosmetic surgery would know whether somebody had that endorsement on their registration. I think it's also important to note, Senator, that this is part of a wider package and ministers have also decided to amend the national law to protect the title of surgeon. And there's substantial work occurring through the Medical Board on essentially strengthening some of the existing guidelines that there are for medical practitioners who undertake cosmetic surgery.

Senator RUSTON: What's the difference between a cosmetic surgeon and a plastic surgeon, apart from the qualification that they have in terms of the procedures that they undertake?

Mr Fletcher: Plastic surgery is a recognised area of specialty.

Senator RUSTON: What's the difference in what they actually do?

Mr Fletcher: The way it works, currently, any medical practitioner could call themselves a cosmetic surgeon and could potentially undertake cosmetic surgery. Obviously the expectation is that they do that within their skills and competence and their education and training, but at the moment there is nothing that stops them doing it, which is why the measure around protecting the title stops them calling themselves the surgeon, and which is why the area of practice endorsement, as I say, would then highlight those practitioners who are undertaking cosmetic surgery having met requirements around minimum standards of training and qualifications.

Senator RUSTON: I'm still at a loss to understand why we are talking about this still, when clearly the word 'surgeon'—I think every Australian understands that the word 'surgeon' needs to be protected. So in protecting the word 'surgeon' through the ministerial council in the direction that will obviously follow into national law—will that prevent somebody who is currently calling themselves a cosmetic surgeon from practising plastic surgery without the necessary qualification to be a plastic surgeon?

Mr Fletcher: Ministers will need to decide in framing the legislative amendment which current areas of specialist registration would be allowed to use the protected title of surgeon. That's something I know the Ministerial Council is looking at. Once that's legislated, it would be an offence under the national law for somebody to hold themselves as a surgeon if they didn't have one of the areas of specialist qualification that allowed them to use that title. It wouldn't stop someone undertaking cosmetic surgery, but they could not call themselves a surgeon.

Senator RUSTON: Can you unpack that for me? Somebody can undertake surgery on someone's face, invasive surgery, and you have no power as a regulator to do anything about that if they don't call themselves a surgeon? I can call myself a cosmetic interventionist and undertake invasive surgery and you have no power?

Mr Fletcher: We would certainly have power to act on that if what was clear was that your performance in undertaking those procedures fell below the standard that was expected, or that you were practising in a way that was outside your education and training and competence. But this is what the review highlighted: that currently any medical practitioner could call themselves a cosmetic surgeon and undertake cosmetic surgery. That will in part be addressed by restricting the use of the title 'surgeon' by amending the national law. The area of practice endorsement will further help by making clear what the minimum standards of training and education are for people who get the endorsement on their registration. That will be publicly available. But the national law doesn't allow us, except in very few specific cases, to prohibit somebody from undertaking a certain practice.

Senator RUSTON: What has been the resistance for AHPRA not making a blanket recommendation that the use of the term 'surgeon' should be protected under national law? None of this endorsement stuff—but that it needs to be protected and, in order for somebody to be able to call themselves a surgeon of any variety, they need to have the endorsement of the AMC and obviously the relevant college that needs to be accredited with AMC to be able to do it. I really can't understand the logic behind saying somebody can be a cosmetic surgeon, even with these extra things that have been recommended that you're proposing to do, and they're not required to have the necessary qualifications that exist under the college of plastic surgeons and that sit with that. It seems quite anomalous to me that your organisation, as the regulator, is going to water down what the Australian public think they're currently protected by in relation to a surgeon, instead of just saying, 'You can't be a cosmetic surgeon'—because a cosmetic surgeon is a plastic surgeon in everybody's mind—'unless you are a plastic surgeon'. What is the resistance to go to that point? What's the logic?

Mr Fletcher: Senator, perhaps I can restate what's in place. We welcome the fact that ministers have decided to protect the title 'surgeon'. We think that is a good step, for all the reasons that you're saying. We think it makes sense for this area of practice endorsement around setting minimum standards for training and qualifications for people who are working in and who want to undertake cosmetic surgery or cosmetic practice, because we want consumers to make safer choices. We're not trying to outlaw an industry here; we just want to help people make safer choices. I think it's premature at the moment to speculate on whether that is going to be a lower standard. It

may well be a higher standard. That's the work the Australian Medical Council are doing at the moment as the independent accrediting body: looking at things like what the required graduate outcomes are, or the outcomes that you'd expect of somebody having this endorsement, and what the required training inputs are. Once that's established in the form of an accreditation standard, which will be approved by the Medical Board, that will then also be reflected in a registration standard approved by the ministerial council, and then programs of study who believe they can meet those requirements will be able to apply for accreditation. I don't think we should assume it's going to be a race to the bottom.

Senator RUSTON: Well, no, that's where we are at the moment, I would suggest.

Mr Fletcher: That's the point of the endorsement. This issue of minimum training and qualifications is not a new issue.

Senator RUSTON: No but I think we're being a little tricky on the words. I still don't understand why AHPRA hasn't come out and said, 'You can't be a cosmetic surgeon unless you're actually a plastic surgeon.' I understand your resistance, but clearly that has been—

Mr Fletcher: We don't have the power to do that, Senator.

Senator RUSTON: You could be recommending it to the ministers.

Mr Fletcher: We support the protection of the title 'surgeon' and we provided advice to ministers to consider around what we think the scope of that should be.

Senator RUSTON: But your recommendation of what that scope could be is around an endorsement and not actually using the existing endorsement that exists within the plastic surgeon's remit.

Prof. Murphy: Maybe, Senator, but for most people to get that required endorsement, they may have to show a level of training which is consistent with the plastic surgery qualification of their colleagues. That's to be determined. But the challenge is that there is no—any surgeon, an orthopaedic surgeon in theory, could do cosmetic surgery at the moment and call themselves 'surgeon'. The only way AHPRA can regulate them is if they practise clearly outside their accepted training, experience and scope of practice. Most medical practitioners work very responsibly within the training that they have, even though the basic medical qualification—GPs do surgery; lots of rural GPs do surgery. They're not fellows of the college of surgery but they do training. They do skin cancer surgery. Most doctors are totally responsible and work within their training and scope of practice. The challenge is that this industry, to be frank, is very different and it needs a separate and special regulatory approach.

Proceedings suspended from 13:30 to 14:40

CHAIR: The committee will now resume. We'll be commencing with AHPRA.

Senator RUSTON: We should be able to deal with this very quickly. Professor Murphy, you made a comment before the lunchbreak that you believe that there was every possibility that the accreditation or endorsement process for cosmetic surgeons under the various activities that are currently on foot could see these particular practitioners qualified in excess even of a plastic surgeon. I'm just seeking an absolute guarantee from Mr Fletcher that this will not mean that existing people who call themselves cosmetic surgeons will be grandfathered into the new arrangements without undertaking the necessary accreditation.

Mr Fletcher: As I said, the Australian Medical Council is doing the work as the independent agency to set the requirements for accreditation, and I would not expect that there would be grandparenting arrangements. There may need to be some sort of transitional arrangement as those new requirements are implemented, but I would not expect that there would be grandparenting arrangements per se.

Senator RUSTON: So you can categorically rule out that this quote is not correct: 'There are some people who are currently doing cosmetic surgery whose training and experience would warrant grandfathering, and there are others whose training experience might not, but clearly there will be some people who'll be so well trained, experienced and qualified that they can be grandfathered'?

Prof. Murphy: They would have to meet the new standard to get endorsement of practice. So, there may be some people who would need that new standard when it's established. But I think what Mr Fletcher is saying is that ministers are clear on the view that, to get the endorsement of practice, you would need to meet the new standard set by the AMC.

Senator RUSTON: You will need to be accredited to that standard?

Prof. Murphy: Yes. To get that endorsement of practice, you would need to demonstrate a level of training and qualification sufficient to meet that standard.

Senator RUSTON: Accredited training?

Prof. Murphy: Yes, the training has to be determined by the AMC. They are looking at what that means.

Senator RUSTON: Is the AMC potentially considering that accreditation or endorsement could be just on the basis of experience?

Mr Fletcher: The AMC is working out what the requirements are both in terms of the educational program and the graduate outcomes, if you like, that would need to be met in order to be accredited. Once that standard is established, it would sit in a relationship with a registration standard, which would be set by the Medical Board of Australia and approved by ministers. Providers who think they meet that requirement could apply to be accredited and, if they were accredited against that standard, that would mean people who had undertaken that training program could then have this area of practice endorsement on their registration.

Senator RUSTON: I put to you that the person quoted was the head of the Medical Board.

Mr Fletcher: I think the point to make is that, if you don't have the endorsement, it doesn't mean that you would necessarily stop undertaking cosmetic surgery.

Senator RUSTON: I think Australians would be very concerned at the lack of clarity that you've been able to provide here today that cosmetic cowboys would be off the market. I think you have only served to make me think that there is going to be an ongoing process of being able to shortcut one's way to a qualification that will enable you to cut up someone's face. I remain very concerned. I put on the record that I am very concerned. Finally, Mr Fletcher, will you be making yourself available to attend estimates into the future?

Mr Fletcher: The ministerial council who we're accountable to when we sought their advice in relation to the invitation to appear before the Senate estimates agreed that we should appear on a one-off basis to aid transparency. If there was a future invitation for us to appear before a Senate estimates committee we would I think need to go through a process again of confirming that health ministers were comfortable with us doing that.

Senator RUSTON: I put on the record that I will be requesting that AHPRA attend future estimate hearings, particularly as I would like to find out what's happening. We have only a four-week process of consultation in relation to this very serious issue. I'd like you back here in February to answer questions about how that consultation rollout has occurred, and how we've gone in changing the national law in relation to the use of the term 'surgeon'. I'll put that on the record now.

CHAIR: Thank you. I will go in order. Senator Rennick.

Therapeutic Goods Administration

[14:47]

Senator RENNICK: My first question is in relation to the number of deaths recorded by the ABS last year. Total deaths last year were—

CHAIR: Are you addressing questions to AHPRA?

Senator RENNICK: No, sorry. TGA.

CHAIR: AHPRA can go. I understand we've exhausted all questions for AHPRA. All of the individual agencies listed under outcome 1 which we haven't already done, including TGA, is what we're dealing with now until four o'clock. I'll be moving through in short blocks. Senator Rennick.

Senator RENNICK: Last year, 2021, we had 171,298 deaths. In 2020 we had 162,592 deaths, which was about 2,000 fewer than in 2019. The rate of deaths increased in May by about 1,000 a month. It jumped by 987 in May, 1,577 in June, 1,396 in July and 495 in August, over the prior months. The reason I'm targeting last year's increase in deaths is there was very little COVID in the community. There was an outbreak in December. Between May and August there were 13 deaths from COVID in July, 90 in August and then none in May/June. Has the department of health/TGA looked at the increase in deaths in 2021 over 2020 and done a temporal association between the date of vaccination and the date of death for the people who passed away?

Prof. Kelly: Just on the general issue of death, we do look at excess deaths, which I think you're referring to there in terms of the Australian Bureau of Statistics figures. We do look at it by month. We do look at it by year. In 2020 and 2021, Australia was one of the very few countries in the world—I believe we're one of five—that did not have increased excess deaths throughout that entire period. I think it's important to take the whole year, because of the seasonality of death rates.

Senator RENNICK: I know where you're going. I'm talking about actual deaths. I'm not talking about excess deaths, which is modelled over five years. I'm talking about the actual numbers. I've adjusted it. There was next to

no population growth last year. There's no trying to average it out for seasonality. There was a constant increase of approximately over 1,000, with the exception of August. There was a big jump in August 2020 in deaths.

Prof. Kelly: There was a COVID outbreak in New South Wales in particular. In terms of deaths in 2020 and 2021, I understand what you're saying about the comparison with previous years. But that's not modelled, that's actual numbers of deaths.

Senator RENNICK: That's exactly right, and I deal with actuals.

Prof. Kelly: I deal with actuals, too. I just wanted to clarify that. I think your question specifically goes to adverse events following vaccination. I think Dr Skerritt is best to—

Senator RENNICK: I will touch on adverse events later on, but I want to know the temporal association, or the time between the date of vaccination and the date of death. I've just had it confirmed by the ABS that they can do that data. Everyone had to download a digital certificate if they wanted to go anywhere. It should be possible to track date of death back to date of vaccination and establish the temporal association between vaccination and date of death.

Prof. Kelly: I'll turn to Professor Skerritt, because he's the one who can talk through the process that we go through in relation to that.

Dr Skerritt: I've talked through the process of identification of causality with deaths before. Just on the Australian Bureau of Statistics numbers, on their website they emphasise that they cannot be used as official estimates—

Senator McCarthy: Can we have the volume turned up?

CHAIR: Broadcasting is adjusting the volume.

Dr Skerritt: The Australian Bureau of Statistics emphasised on their website that the statistics they put out cannot be used as estimates of excess death. During that period, a number of actuarial experts emphasised that, if excess deaths were due to vaccines, the actual increase in deaths would have been of younger people. If you look at the age breakdown of those excess deaths, they are largely in the over 75s. As far as your other measure, a time lag between vaccination and death doesn't necessarily infer causality.

Senator RENNICK: No, I realise it doesn't necessarily, but it might infer causality. Between April and July the major cohorts that were vaccinated were older people. You're right; it's the older people who've had the rapid increase in deaths, at about 10 per cent; the younger people were all locked down. Their death rate fell, because they weren't having workplace accidents. I'm familiar with that. Again, you have a responsibility here. Given the jump in deaths from May onwards, you cannot rule out that it was from the vaccine, can you?

Dr Skerritt: As I've indicated before, we look at every death that is reported as being potentially temporally related to vaccination, and we refer any that are of particular suspicion to a committee of external experts. In that data there were also increased numbers of deaths that were attributed to cancer, dementia and ischemic heart disease. Of course, during lockdown there were fewer other infectious diseases, because of social isolation. The ABS statistics have not been seen by any of the professional group such as the actuaries, who make a living out of doing this, as being associated with vaccination.

Senator RENNICK: Have you done a correlation between the date of death and the date of vaccination? It's a simple 'yes' or 'no'?

Dr Skerritt: For the cases where there are deaths reported we do look at the date of vaccination. We don't see a correlation—

Senator RENNICK: Can you please provide a copy of those dates of deaths and dates of vaccination.

Dr Skerritt: We'll provide that—

Senator RENNICK: Secondly, last time I spoke about lipids and you said they were like the normal lipids in an everyday sausage that you have for breakfast. That's not what Pfizer has said. On their own website they have said that the lipids used in these vaccines aren't an everyday lipid that's regularly available. They had to come up with a new type of lipid. It's a cationic lipid, and it was the one that contained the lipo nanoparticle. It's well known that cationic lipids can disrupt mitochondrial cellular respiration, which is responsible for consuming oxygen or producing energy. They are known as reactive oxygen species. Why did you say these were normal lipids in the vaccine when they're ionised lipids, which changes their characteristics completely, from hydrophobic to hydrophilic, and which can transfect any cell and don't rely on an ACE receptor to enter the cell, hence increasing infectivity?

Dr Skerritt: Firstly, lipids and lipid nanoparticles do not rely on ACE receptors to enter cells. I think you've got your biochemistry confused. There are four different lipids in the lipid nanoparticles. Two of them, as I indicated earlier, are naturally occurring bodily lipids. In the lipid nanoparticles we have cholesterol and distearoylphosphatidylcholine. Both the Moderna and Pfizer vaccines do contain two other lipids. These lipids have been used in a number of other products. For example, the Moderna two lipids have been tested as to whether they're genotoxic in bacterial mammalian cell lines. There are globally recognised standards for testing pharmaceuticals that all countries adhere to from the international conference on harmonisation. The levels of lipids in these nanoparticles are below the threshold for toxicological concern for genotoxicity, based on the International Conference of Harmonisation, which all OECD countries align with.

Senator RENNICK: Thank you.

CHAIR: I am going to move the call. I'm doing 10-minute blocks to try to get through as much as we can by 4 o'clock. Senator McGrath.

Senator McGRATH: I have questions for the TGA also in relation to vaping. How many authorised prescribers for nicotine vaping products are there as at today's date?

Dr Skerritt: As I advised earlier, the term 'authorised prescriber' is frankly highly misleading, because any of the 130,000, I think we heard from AHPRA earlier today, registered medical practitioners in Australia can prescribe nicotine for vaping. An authorised prescriber can prescribe for any number of individuals. Therefore, it simplifies the process. As of 15 October—these numbers, unfortunately, are almost a month out of date—there were 1,353. I would guess there's probably about 1,400 to 1,500 by now that have the special authorisation to prescribe for any number of patients in Australia.

Senator McGRATH: In February this year I put a question on notice asking what engagement the TGA had with social media companies around the unlawful advertising and supply of nicotine vaping products. Your response was that you had preliminary discussions with Facebook. Have you since engaged with any other social media platforms?

Dr Skerritt: Yes. The engagement in fact was not on nicotine but on melanotan, which is quite a dangerous tanning product promoted on social media. We have very close relationships with all the major social media groups, whether it be Alphabet, Facebook or TikTok. I'm sure I've left out a few. We do three things with them. Firstly, we identify the sorts of products that we ask them to flag and to use their algorithms to block, with keywords such as nicotine, melanotan, bodybuilding and so on. Those keywords aren't foolproof, because there are other words that are used by people to get around it. Secondly, we flag with them suspicious or worrying posts. Generally, they take them down. Thirdly, we meet with them every couple of months to talk about compliance priorities.

Senator McGRATH: On your website you state that TG0 110, which I understand to be the standard for nicotine vaping products Order 2021, will be reviewed 6, 12 and 24 months after its implementation. It's been 13 months since implementation, and I understand no reviews have been released. Can the TGA provide details of what reviews are currently being undertaken and how the reviews have been conducted? Can the TGA also provide a breakdown of when these reviews will be released?

Dr Skerritt: This has been an active area of discussion with the minister and government ever since the May election. Indeed, a range of things has happened, including that on 30 September Minister Butler convened a roundtable of vaping experts to discuss potential requirements for policy and regulatory reforms. He has given a commitment to public consultation on possible reforms. He's also given a commitment to consultation with states, territories, healthcare professionals and community groups. That process has supplanted the idea of getting an independent group of academics to review the process. There's a view by government that as a matter of urgency the dramatic increase in youth vaping needs to be addressed. Currently the plans for next steps are before the minister and the decision hasn't yet been made as to exactly what will happen when.

Senator McGRATH: Whom was on the roundtables?

Dr Skerritt: I'll take the full list of attendees on notice. I imagine they are public, but we may have to seek their consent through the minister for their names to be released.

Senator McGRATH: I last asked the TGA back in February—it was question on notice SQ22-000180—have there been any further discussions between the TGA or the department of health with the Department of Home Affairs about the volume of disposable Chinese-made vaping products reaching Australian shores and into Australian schools?

Dr Skerritt: There have been. It is a major problem. Again, one of the things that will be considered by the minister is whether there need to be further changes to the approach taken at the border. As I said, all of these

things are before the minister to look at what steps he wishes to consult with the states and territories, consumer groups, healthcare professionals and the public in the coming months.

Senator McGRATH: I asked a question on notice also back in February, SQ22-000173. The TGA stated in its reply:

Testing for prohibited ingredients is not performed if the product does not contain nicotine … Of the 126 products where nicotine was detected, 42 products (33 per cent) were found to contain one or more prohibited ingredients … Of the 126 products that were found to contain undeclared nicotine, 22 per cent of these products originated from China, 0.8 per cent originated from Hong Kong and the remaining 77 per cent were of unknown origin.

I think we can take from this answer that, of all of the offending products where country of origin was stated, 96.5 per cent came from China. Of those 126 products, 39 per cent contained at least one prohibited ingredient. I'm just going to assume—and please correct me if I'm wrong—that all of these products were disposable nicotine vaping products and came from a handful of Chinese manufacturers, Gunnpod, IGET and HQD, the same vapes that keep turning up in schools. If we know that China is accounting for over 90 per cent of offending products and roughly 40 per cent contain harmful ingredients, why not just ban the importation of Chinese vapes or at least ask the Australian Border Force to set them aside for testing before they're released?

Dr Skerritt: As I've indicated, for example, whether the requirements of TGO 110 should be strengthened and whether there should be further actions at the border are under consideration by government. I can't comment on particular policy options.

Senator McGRATH: You also stated in the answer that you don't test for prohibited ingredients where nicotine is not detected. You may have touched on this, but whom is responsible for testing those products for prohibited ingredients?

Dr Skerritt: We base our testing on intelligence. As you've indicated, we've found a number of prohibited ingredients in certain vaping products. The initial screening that we carry out is where we suspect there may be nicotine even though it's been hidden or not declared. We don't have a blanket approach. It's intelligence led. Our resources do not permit us to test every vaping product for every potential ingredient, and so it does have to be driven even by such things as mining the dark web, looking at the internet, looking at social media, looking at prior testing, and looking to other countries, and Interpol. We gather a lot of intelligence. That has to direct our testing. We just don't have the resources—and I doubt anyone would—to test every product for every substance.

Senator McGRATH: If prohibited ingredients such as diacetyl are exponentially more harmful for people than nicotine, does the fact that the TGA has no interest in testing for the more harmful and banned ingredients make this regulatory regime self-defeating?

Dr Skerritt: No, I didn't say that. I said we use intelligence. It's the same even with prescription medicines; if we've got intelligence that it's a reputable supplier—and you've talked about some companies having a particular risk—we are less likely to chase those other ingredients if we've found earlier that their products, or others globally, have found that their products are free of, for example, diacetyl. Of course, the concentrations make the toxicity. As I've indicated, it's intelligence led. Nobody has the resources to test every product for every substance, and the same goes for prescription medicines, never mind vaping products.

Senator McGRATH: Why should this not sit with a regulatory body that has regard for the safety of all products rather than those that just contain nicotine? Surely the ACCC is better placed to run this than the TGA? I'm concerned that there's such a narrow scope in relation to the responsibilities in terms of the testing of these products.

Dr Skerritt: TGA only has a legal remit for when products are therapeutic goods, either medicines or medical devices. Under Australian law, a non-nicotine containing vaping product is not a therapeutic good. The government is considering what it should do about the regulation of non-nicotine containing vaping products. As I've said, the deliberative process prior to consultation is under way. It is up to government what agency is responsible for what function.

Senator McGRATH: I do have more questions.

CHAIR: I'll try to come back to you. Senator Canavan.

Senator CANAVAN: I have some questions on vaping, but I did want to follow up on Senator Rennick's line of questioning on the provisional mortality statistics of the ABS. Obviously, this is running at a rate 17 per cent higher than the historical average. What is the department of health's or the TGA's view as to why that's occurring?

Prof. Kelly: I did refer to Senator Rennick's question earlier about 2020 and 2021. 2022 is a different story. As you've pointed out, we are now in an excess mortality position. Some of that, of course, is due to COVID related deaths from people who have had acute COVID. I will point out, as I did to Senator Rennick the other night, that vaccination has been an absolute game-changer in terms of protection against those deaths.

Senator CANAVAN: I have very limited time. I more want to focus on the question I asked. Why are we running with excess deaths?

Prof. Kelly: Part of that is due to actual COVID deaths. There has been, as Professor Skerritt referred to earlier, an increase in other causes of death—dementia, cardiovascular disease, respiratory illness, and so on. Many of those are up. We're still investigating why that might be. It could be partly due to people not receiving the best care for their chronic diseases over the last couple of years because of the indirect effect of COVID. It could also be due to longer term effects of COVID itself.

Senator CANAVAN: Is there a team investigating this within the department of health?

Prof. Kelly: Absolutely, yes. We're looking very closely at the data and we're working with our other agencies. There's a specific process that I mentioned earlier in relation to the parliamentary inquiry on long COVID, and the commitment from Minister Butler to have a plan in relation to that.

Senator CANAVAN: Are you planning to release publicly the findings that team makes about excess fatalities?

Prof. Kelly: Some of that information will be part of our submission to the inquiry in the other part of this building. But then, yes, there will be further work. We're also doing some excellent work with Victoria at the moment.

Senator CANAVAN: I might leave it there, because I only have 10 minutes. When do you expect to finalise conclusions?

Prof. Kelly: In terms of the cause of death?

Senator CANAVAN: Have you said to your team, 'I want answers by this date'?

Prof. Kelly: I'm not sure whether Dr Gould is here.

Dr Gould: I have a team at the moment looking at a range of linked datasets to help us better understand causes of death across a range of conditions, including COVID-19. It's really important when you do this sort of analysis that you take into account—

Senator CANAVAN: Sorry. I just want an answer to when you might conclude that work. I am really sorry. I wouldn't normally be this abrupt; I've only got limited time.

Dr Gould: We have an ongoing program of work to discuss—

Senator CANAVAN: So, no end date at this stage?

Dr Gould: We will make information available.

Senator CANAVAN: I appreciate that. I want to turn to vaping, more to Professor Skerritt. I'm referring to some recent data collected by the Cancer Council, which finds that only 8.6 per cent of Australians who use liquid nicotine and vaping products have a prescription or are effectively complying with the prescription model. Have you done any work on this? Does that statistic sound correct?

Dr Skerritt: We've had those figures quoted to us. We don't have any way of verifying it. Clearly, it shows there is still an unacceptable level of nicotine vaping products getting to our children and adolescents. This is why the minister—

Senator CANAVAN: No. My question didn't mention children or adolescents at all. It's simply that, of the 500,000 vapers in Australia, the vast majority of whom are adults, apparently only one in 10 have a prescription. Do you have any work on compliance with your regulation?

Dr Skerritt: We don't have information on the number of people who might be obtaining it illegally.

Senator CANAVAN: Just anecdotally, you'd know this talking to people. A lot of people aren't getting prescriptions. It's not exactly working. Isn't the situation here that a regulation which is not being complied with is actually helping create the conditions for a black market that generates the outcomes referred to earlier of making it more accessible to younger Australians?

Dr Skerritt: I don't know how it creates a condition. The question is whether we have the appropriate framework in place. That's why, as I've said, the government, soon after election, wanted to look at how it could

be reviewed. Their major concern is children, similarly with principals and parents. They're very concerned about children and adolescents accessing it. The framework is being reviewed.

Senator CANAVAN: I completely accept that. I don't think anyone would disagree that having these products accessible to young children is reprehensible and should be combatted. The issue is how effective the current regime is. It doesn't seem that effective at all. There was a question on notice from Senator Abetz, SQ22-000080. You mentioned the review after the election, but there was also, in reference to his question, a 12-month evaluation. You referenced that you would do an initial evaluation after about 12 months of the prescription model. How is that evaluation progressing?

Dr Skerritt: As I indicated earlier, very soon after the election we met several times with the minister to look at what was working and, as you've indicated, worries about access by children and young adults. It's going in a different direction, as I indicated. The minister brought together some experts in the field and is considering next steps at the moment. It's going in that direction rather than an independent review. The urgency to make sure our children and adolescents don't access nicotine for vaping is extreme.

Senator CANAVAN: So, the initial evaluation you referred to in Senator Abetz' question is redundant now? You're not progressing that at all?

Dr Skerritt: That response was prior to the change of government, and the minister is looking at alternative approaches.

Senator CANAVAN: In another answer to Senator Abetz, SQ22-000003, regarding illicit vape sales to young Australians, the TGA said that it does not accept responsibility for the unlawful supply of NVPs—nicotine vaping products—to children. I was a little bit shocked at that answer. Are you saying you have no responsibility to regulate this? I'll be very clear that I'm not trying to blame you for all provision of these products. Obviously it's not your fault, but I would have thought you'd have some oversight here.

Dr Skerritt: Within the current regulatory framework, it is intended to stop access for children and young adults, but clearly it is insufficient. It's not working well enough at the moment—

Senator CANAVAN: I agree.

Dr Skerritt: because children and young adults can go to tobacconists, they can go to convenience stores and they can buy product over the internet. There are many ways around the current regulatory framework, which is why the government is reviewing it. But the TGA is not—

Senator CANAVAN: I agree completely. Given the time, I have some other questions that I'll put on notice. I would just say again that it seems to me we should focus our enforcement efforts on the young, not on the old and not on consenting adults.

Dr Skerritt: That's what we do.

National Health and Medical Research Council

[15:16]

Senator CANAVAN: I have questions on NHMRC. Sorry to be jumping around a bit, but I'm trying to facilitate the committee as much as possible. Are they in this block? Should I come back?

CHAIR: We are moving through all of the agencies listed in outcome 1, not in order.

Senator CANAVAN: I refer to an article on 24 June 2021 in the *Australian* titled 'Greg Hunt orders review into risky Wuhan research'. In that article the minister is referred to as stating that the NHMRC has been tasked with undertaking a review of gain-of-function research that might be conducted with our government or a policy in regard to it. Could you give me an update on that review?

Prof. Kelso: We completed the review for Minister Hunt and provided him with the report in March, and it went up on our website on 8 April 2022.

Senator CANAVAN: I apologise; I haven't been following your work as closely as I should. What did that find? Have we done any gain-of-function research in Australia?

Prof. Kelso: The review examined Australian government funded research in Australia over the last 10 years. We had a committee from within government and an expert adviser review all potential projects. It reviewed 6,000 projects funded by NHMRC, the ARC, undertaken at CSIRO and around the country. Out of the 6,000, it found 17 projects where there was gain-of-function research that could be considered of concern. We examined whether all of those projects had the appropriate regulatory controls and whether there had been any incidents that could have been of concern, and everything was in order.

Senator CANAVAN: Did any of those 17 involve researchers either from the Wuhan Institute of Virology or researchers who had been researchers at the Wuhan Institute of Virology?

Prof. Kelso: Not to our knowledge. The Wuhan Institute of Virology wasn't a named participant in any of those 17 projects.

Senator CANAVAN: Did any of the 17 relate to coronaviruses?

Prof. Kelso: I don't recollect whether any of them were to do with coronaviruses.

Senator CANAVAN: You can take that on notice. Is gain-of-function research allowed/legal under Australian government guidelines?

Prof. Kelso: A great deal of very useful, positive gain-of-function research is undertaken around the country. It's an essential technique in modern molecular biology. In fact, a great deal of what we know about viruses, about the current coronavirus, SARS-CoV-2, the procedures that we used to make, for example, the AstraZeneca vaccine for COVID-19—these have all used gain-of-function research techniques.

Senator CANAVAN: And possibly the creation of SARS-CoV-2?

Prof. Kelso: No. Gain-of-function research, by its nature, involves the—

Senator CANAVAN: Possibly it could have led to the coronavirus pandemic?

Prof. Kelso: Not to my knowledge, and there's no evidence that any work was done in Australia.

CHAIR: I need to share the call.

Senator CANAVAN: Finally, what are the guidelines? Are there guidelines for researchers in Australia doing gain-of-function research?

Prof. Kelso: Yes. The report on our website outlines the very wide range of regulatory processes in place from ethics all the way through to the work of the Gene Technology Regulator.

Senator CANAVAN: We'll come to this, I'm sure.

CHAIR: I will come back to you, if I can, before the tea-break.

Senator CANAVAN: I am in other estimates today.

Therapeutic Goods Administration

[15:20]

CHAIR: Senator Roberts.

Senator ROBERTS: Can you tell me how many medicines were approved under the provisional approval pathway during the COVID period 1 July 2020 to date? My numbers are 13 vaccines and six drugs; is that correct?

Dr Skerritt: Are you talking specifically about COVID treatments and COVID vaccines?

Senator ROBERTS: No, any vaccines or drugs that have been approved using the provisional pathway.

Dr Skerritt: I will start with COVID vaccine treatments. There have been seven COVID vaccines and eight COVID treatments. I'll just check whether I've got the numbers for other medicines during that period. You're talking about the provisional approval pathway?

Senator ROBERTS: Yes.

Dr Skerritt: From 1 July this year there have been five provisional approvals. From the period 1 July 2021 to 30 June 2022 there have been 23. That would include those COVID treatments. What it does show is a lot of other medicines, such as cancer medicines, such as medicines for rare conditions, have also been approved. In the financial year 2021, from 1 July 2021 to 30 June 2022, there were five. Over the period you're talking about, that would add up to 33.

Senator ROBERTS: How many drugs have been approved under the normal process during that same period?

Dr Skerritt: During the same period? I will add the three financial years and I'll check my mental arithmetic. So 36 this current financial year, and 117. These are either new approvals or new indications approved. And 95 the year before. So, it is a significant percentage, but not most of them.

Senator ROBERTS: Is the maximum provisional approval period six years because it can take that long to get drugs approved under the old approval system?

Dr Skerritt: A provisional approval is only valid for two years and then the company either has to come back and show why they cannot obtain all the data within the period and apply for an extension.

Senator ROBERTS: No, the maximum provisional approval?

Dr Skerritt: They can apply for further lots of two years.

Senator ROBERTS: Is the maximum provisional approval—

Dr Skerritt: Overall the maximum period is six years, but it's not six years off the bat.

Senator ROBERTS: It's two years with extensions.

Dr Skerritt: They are possible extensions; they're not guaranteed.

Senator ROBERTS: How much money do you save pharmaceutical companies by switching from full approval to express approval? I understand it's hundreds of millions per approval?

Dr Skerritt: It actually costs the pharmaceutical companies more in regulatory fees for provisional approval.

Senator ROBERTS: No, I didn't say regulatory fees. How much are you saving the pharmaceutical companies by giving them express or provisional approval rather than going through the six-year period for getting proper approval?

Dr Skerritt: No, you've misinterpreted the system. It's not a six-year period to get full regulatory approval.

Senator ROBERTS: It varies. I accept that.

Dr Skerritt: Most of our approvals are submitted as a standard approval, especially, for example, if it wasn't a public health emergency or it's a drug that already has others in the same category. They're submitted as a standard approval.

Senator ROBERTS: Dedicated trials for their drugs, I understand, can be hundreds of millions of dollars. How much time and money would they save by going express?

Dr Skerritt: We would not give a provisional approval to a medicine unless there were clinical trials.

Senator ROBERTS: How much money does it save if they do a provisional without doing a formal or normal approval process? How much money does it save the drug company?

Dr Skerritt: I don't believe there are necessarily savings. The situation would be different for every drug. It's really important to emphasise there were very extensive clinical trials for the vaccines and treatments that have been through provisional approval.

Senator ROBERTS: My understanding is that it can cost hundreds of millions of dollars to get the full approval process. Without the dedicated trial, they could save hundreds of millions of dollars per drug?

Dr Skerritt: I don't necessarily agree with you.

Senator ROBERTS: When does the provisional approval for Pfizer expire?

Dr Skerritt: The two-year period will be two years from the anniversary of the first approval. I would emphasise that in certain countries—

Senator ROBERTS: What is that date?

Dr Skerritt: The products are now fully approved.

Senator ROBERTS: What is the date of provisional approval expiry?

Dr Skerritt: For the very first approval, for 16 years and over, the two-year period finishes on 25 January 2023.

Senator ROBERTS: I have in front of me a document called the Australian Public Assessment Report for Tozinameran, from Comirnaty (Pfizer), dated December 2021. Is this the approval application for the paediatric version of the Pfizer vaccine?

Dr Skerritt: No, it is not. An Australian Public Assessment Report is a summary of the assessment that we did of the application. You mentioned Pfizer. The actual application is over 220,000 thousand pages of paper from Pfizer for that particular group of vaccines.

Senator ROBERTS: I reference page 61, which states:

Limitations of the current application data. Safety follow-up is currently limited to median 2.4 months post dose 2 in cohort 1, and 2.4 weeks for the safety expansion cohort.

What is the safety expansion cohort?

Dr Skerritt: Remember, also, this was going back to the time of approval. We now have hundreds of millions, actually more than a billion, people who have been vaccinated with that vaccine and experience going on since December 2020, when the first vaccination was done. The safety expansion cohort is in a clinical trial where

individuals are monitored closely and the data reported back to regulators for periods of months, leading to years, after their vaccination.

Senator ROBERTS: Did you recommend this substance based on 2.4 weeks of safety testing or did you get more in? If so, over what period? How many months?

Dr Skerritt: Remember the initial approval from TGA was based on that two months of follow-up, but we also had the experience of other countries that had more than a month before starting mass vaccination campaigns. When we approved Pfizer on 25 January2021, we were in almost daily contact with the British, who by that stage had vaccinated millions of British people by 25 January 2021. Real-world evidence played a very important role in both the approvals and in the ongoing safety monitoring of these vaccines.

Senator ROBERTS: So you relied on data from other countries and you relied for periods of months, merely months. It can't be more than six months, because there's a gap between application and approval and to give time for collection of data and analysis. There should be years of data before we start putting this stuff into our children, yet it's months.

Dr Skerritt: I disagree in the context of a pandemic and a public health crisis. Regulators globally felt that it was appropriate to do initial approvals—

Senator ROBERTS: You're the Australian regulator.

Dr Skerritt: As the head of the Australian regulator, I would do precisely the same if I had my time again. The alternative would have been to leave Australians unvaccinated through the course of 2020, 2021 and 2022, and there would have been tens of thousands more Australian deaths.

Senator ROBERTS: Can I reference a letter from the Commonwealth Department of Health and Aged Care, signed by Radha Khiani, Director, Governance and Coordination section, in which the department makes this claim. The letter from 4 November 2022, just last week, states:

A large team of technical and clinical experts at the TGA carefully evaluated the data submitted by the sponsor. A treatment or vaccine is only provisionally approved if this rigorous process is completed.

This document concerned the use of Pfizer stages 2 to 3 cynical trial data in support of their application for provisional approval. Did the TGA check the stage 2 and stage 3 clinical trial data from Pfizer? Did you check it?

Dr Skerritt: We did check the phase 2 and phase 3 clinical trial data from Pfizer and we also took it to independent external medical experts as well as consumer representatives.

Senator ROBERTS: Referencing Freedom of Information No. 2289, in which the applicant requested a copy of the stage 2 and stage 3 clinical trial data, the TGA responded that the 'TGA does not hold any relevant documents relating to the request'. That was a request for stages 2 to 3 clinical trial data.

Dr Skerritt: Without seeing what's in your hand, I believe that you asked for individual patient data rather than the phase 2 and phase 3 clinical trial data. I can give you my word that we assessed the phase 2 and phase 3 clinical trial data; otherwise, what else did we do? Look at the colour of the label on the bottle? That is the main thing our team of several thousand clinicians look at in reviewing a new vaccine, the phase 2 and phase 3 clinical trial data. It is the centrepiece.

Senator ROBERTS: The freedom-of-information request then asked for 'any documents confirming the process of analysing this data to a decision, including meetings, notes, dates and times'. Again the TGA replied, 'We have no relevant documents.' Did you review the stage 2 and stage 3 data or not, and, if you did, why did you tell this freedom-of-information applicant you did not have these documents? Which document is the lie? One of them is.

Dr Skerritt: I don't have that document in front of me. We can review it on notice. But we reviewed the phase 2 and phase 3 clinical trial data at length.

CHAIR: This really needs to be the last one so I can share the call.

Senator ROBERTS: I just want you to think about this and confirm it or otherwise: and 'the trail data contained sufficient proof the vaccines were safe and effective, sufficient to meet the criteria for provisional approval'; is that correct?

Dr Skerritt: Correct. Yes.

CHAIR: Senator Cadell.

Senator CADELL: I want to go back to vaping, if I can. Is it still the advice to government that nicotine vaping products should not be sold in Australia except through prescription?

Dr Skerritt: Yes, it is.

Senator CADELL: I come at this from a different point of view. I am a nonsmoker, never smoked a thing, don't do it, and have advocated against Big Tobacco donations. I heard research quoted by Senator Canavan that over 90 per cent of people vaping in Australia are not doing so through legal means. I had trouble believing that. Once again, do you think that's a possible number? You haven't seen numbers, but is that possible?

Dr Skerritt: I think it is quite possible, because it is very easy for people to break the law. The question is: how can the system be strengthened so that our children and young people don't get access to nicotine vaping substances?

Senator CADELL: Do you accept that all but two of the OECD nations have legalised and regulated tobacco vaping products for sale without prescription?

Dr Skerritt: That is a fact, and I think Australia should be very proud of what we have done in vaping, the same way as we should be very proud of what we've done with plain packaging of tobacco.

Senator CADELL: In making this decision, what information do we have that these other nations, including New Zealand, which regulated in February, don't have?

Dr Skerritt: I think we're in a situation where in some of these other countries the horse has bolted. The impact on youth vaping rates and on smoking rates is evident. I was recently in the US with the USFDA. Their tobacco centre is essentially playing catch-up in a system where they've had an explosive increase in the number of young people vaping. And now by trying to almost in retrospect regulate products on the market and take products off the market that, for example, may be particularly attractive to young people, they are playing catch-up. They are also caught up in the courts with that.

Senator CADELL: Is it your testimony that the horse hasn't bolted in Australia? Over 90 per cent of users do so illegally. I'll get to the point. I've been in Canberra for three months. Within 10 kilometres of here, in 10 minutes today, I was able to buy a nicotine vaping product without knowing anyone. The horse has bolted. You surely can't say it hasn't?

Dr Skerritt: No, I think the government is currently considering what they can do to manage this problem for our children and young people. We could put up a white flag and give up, but I don't think that is the view of the government.

Senator CADELL: My son, who is 16 years old, is president of his SRC; Lachlan, his brother, 13 years old, is also in the SRC. They are fundraising to try to buy vapour detectors for their bathrooms because it is rampant in their school. They can't stop it. It is too late to lock the gate on this. You're saying we got in early. We haven't, surely?

Dr Skerritt: I disagree that it's too late to lock the gate. If we give up like that on all matters to do with public health, Australia would still have the smoking rates, for example, that we had in the 1970s.

Senator CADELL: If we make it financially viable to do illegal acts and create illegal activity in Australia, surely they will not care if they sell it to kids or whoever. Is that not right?

Dr Skerritt: There needs to be mechanisms whereby those breaking the law can be more readily detected, and it is practically harder for people to put out vaping products. For example, we have vaping products at the moment with rainbows and unicorns on them that surely appeal to adolescents. Do we need to have something that's a prescription medicine with rainbows and unicorns? Those are the sorts of things being looked at.

Senator CADELL: I had the choice of purple haze, berry blast, melon madness, bliss berry and pink lemonade today. Surely—

Dr Skerritt: Should we have flavoured products? These are things that need to be considered and consulted on publicly. Those flavoured products do attract young people.

Senator CADELL: Have young adults or children died or suffered serious health effects from vaping in Australia?

Dr Skerritt: There have been poisonings of toddlers due to nicotine vaping products. There is evidence—and again I know there are various studies on their way to being reported—of respiratory, psychological and other impacts on teenagers and youth from vaping. I think it would be dangerous to assert that these are harmless products. In fact, there's been a fair bit of media from parents and children themselves indicating that nicotine is not a benign substance.

Senator CADELL: Do we think that these babies and young adults are getting prescriptions and buying this from New Zealand legally?

Dr Skerritt: No. They're getting it, as you say, from tobacconists, convenience stores, over the internet, and various mechanisms. The question is: how do we enable people who appropriately want to use nicotine vaping products under their doctor's supervision for smoking cessation but stop children and young people gaining access to them and suffering from the damaging effects of nicotine on developing adolescents?

Senator CADELL: I am not pro vaping. I am anti bad laws. This law has failed. This law is failing. It is time to look at other solutions. I accept we'll look at what the new government will do to tighten up this stuff. If this situation exists in the next six and 12 months after this change, will you commit to reviewing regulation in Australia so these products, as harmful as they might be, can be regulated in a more effective way and constrained better through retailers than they are now?

Dr Skerritt: If they are prescription medicine, it's appropriate for a retailer to produce them. You don't go to a 7-Eleven to get morphine, for example. I give my absolute commitment that we are looking at better regulation of these products. The regulation certainly needs to be improved. It's not good enough now. That is what's before government for decision in terms of what can solve this.

Senator CADELL: I couldn't believe I could get this so quickly. Thank you for your time.

Dr Skerritt: I agree with you. I could get it in 10 minutes.

CHAIR: I owe you a coffee for getting through your block quicker than planned. Senator Steele-John.

Senator STEELE-JOHN: As to the TGA, I take you now to the interim decisions in relation to psilocybin and MDMA released, I think, on 21 October 2022, where the delegate opposed their rescheduling. MDMA and psilocybin are illegal in most Australian jurisdictions. Do you know which states or territories have exemptions so that patients can access these substances for medical use?

Dr Skerritt: States and territories are enabling access for supervised clinical trials. However, very few jurisdictions are enabling their access through the special access scheme. But they are available for clinical trials. The view of the scheduling delegate, and on the advice of the advisory committee, was that they seem to have considerable promise but they were not yet shown to have a place in therapy. There are some major trials under way globally that we expect we will have results in the next year. They are always open to reconsidering the decision if more evidence comes to the fore. At the moment in most jurisdictions they can be accessed. Sometimes they require a special permit from the director-general, because of the scheduling nature for clinical trials.

Senator STEELE-JOHN: I want to check that I heard you properly over the line. Did you say that most states and territories have special access exemption schemes?

Dr Skerritt: No, I said clinical trials exemptions. Most states and territories—

Senator STEELE-JOHN: Yes, sorry. Clinical access.

Dr Skerritt: But in some states and territories it does require an additional permission from the secretary for health or from their police department, because of the nature of the substances. They are not easy to access for clinical trials, but there are clinical trials underway.

Senator STEELE-JOHN: To your understanding, is it the case that every state and territory has such a clinical trial access process?

Dr Skerritt: It does vary between states and territories. As I've indicated, some of them are extremely challenging and you have to get a separate narcotics permit. Others are more straightforward. I wouldn't say there are clinical trials underway in every state or territory. The main clinical trials that are being looked at are ones being conducted in the US and in Europe, because they're the bigger trials, and there are some very large ones that will be reported on in the coming year.

Senator STEELE-JOHN: Just to clarify, to the TGA's knowledge, every state and territory has a process; it's just that in some states and territories it's more difficult to access than in others?

Dr Skerritt: They have a process, but in some states and territories it does require either a formal regulation to be made or a formal permission to be obtained from either the director-general of health and/or the commissioner for police. I wouldn't want to say it's as simple as doing a clinical trial for other substances.

Senator STEELE-JOHN: When you say there is a regulation that has to be made, which states and territories are you referring to?

Dr Skerritt: I'll have to take that on notice, because the system is changing. We can take that on notice. We always like to check with the states and territories, when reporting on current things under state and territory law, that it's still accurate. Can we take on notice the situation in each state and territory?

Senator STEELE-JOHN: If there is a state or territory in which a regulation is required but it has not to this point been created, that would mean that, as of now, there wouldn't be a process until that regulation had been created?

Dr Skerritt: Some states and territories can make regulation, not legislation, which has to go through a parliament. Some states and territories can make a regulation, for example, based on a brief with their health minister. What I suggest we do is we document the situation in each state and territory for you on notice.

Senator STEELE-JOHN: In relation to the delegate decision, the delegate stated in the ruling that therapeutic value of psilocybin and MDMA was yet to be established, yet submissions to the open submission process included letters from leading experts that stated clearly therapeutic value has indeed been established. These experts include Professor Arthur Christopoulos, Dean of Monash University's Faculty of Pharmacy and Pharmaceutical Sciences. In addition, 100 per cent of submissions from registered health professionals supported it, as did 97 per cent of researchers and 99 per cent of public submissions. Could you share with me the qualifications of the delegate who made this decision?

Dr Skerritt: We have several delegates, all of whom have both medical qualifications and postgraduate convocations in various areas, such as public health and pharmacology. We have several delegates. The delegate acts as a direct delegate of the secretary in making that decision and in looking at the evidence. They also act on the advice of the Advisory Committee of Medicine Scheduling, which consists of medical doctors, again public representatives and representatives of the states and territories. While they do not formally vote, there was not support among the advisory committee for rescheduling.

Senator STEELE-JOHN: Yes, I understand that is the case in the general sense. I'm referring specifically to the delegate who made the decision in relation to psilocybin, which was released on 21 October 2022 as a result of that decision. I want to know the qualifications of that particular delegate.

Dr Skerritt: That particular delegate is a medical doctor with three university degrees and 20 years of experience in pharmacology as well as postgraduate qualifications in public health.

Senator STEELE-JOHN: Does that include a psychology or psychiatry degree or qualification?

Dr Skerritt: The delegate was informed by advice from both the Australian Psychological Society and the Royal Australian and New Zealand College of Psychiatrists, the two peak bodies for psychologists and psychiatrists, and both of those bodies were strongly opposed to down-scheduling psilocybin and MDMA. The peak bodies of psychiatrists and psychologists both strongly opposed down-scheduling, and so that was where the psychiatric and psychological advice also came from.

Senator STEELE-JOHN: So, we've got a situation here where leaders in psychedelic medicine research, health professionals, consumers and members of the public who have significant qualifications in this space made submissions to this process in relation to the rescheduling of psilocybin and MDMA—again, I'll put to you the 100 per cent support rate from the registered health professionals who submitted, 97 per cent of researchers and 99 per cent of the public—and yet the delegate made a determination that it should not be rescheduled?

Dr Skerritt: Correct.

Senator STEELE-JOHN: Can you share with me what research, evidence or otherwise the delegate took into consideration that lead to their decision?

Dr Skerritt: Yes. Firstly, I think your statistics are a little bit misleading because, as I've indicated, the Australian Psychological Society—

Senator STEELE-JOHN: In what way are those statistics misleading?

Dr Skerritt: In what way? They are the peak representative body, the APS.

Senator STEELE-JOHN: No. In what way were those statistics misleading?

Dr Skerritt: You said that 100 per cent of health professionals supported rescheduling, and I've said that the two peak bodies—

Senator STEELE-JOHN: That made submissions to the inquiry.

Dr Skerritt: of psychologists and psychiatrists opposed it. The Australian Psychological Society and RANZCP also put submissions in, and they represent some thousands of health professionals. That's what I was picking you up on, because we have two peak bodies that were strongly opposed. I'm just telling you how it is; I'm not giving a personal opinion.

CHAIR: Senator Steele-John, I'm about to hand over the call.

Senator STEELE-JOHN: Yes. I'm just going back, beyond those two recommendations, to the research that was relied on by the delegate in making the decision.

Dr Skerritt: The delegate went through all the published papers on clinical trials and looked at the size of that collection. I should also add that we commissioned an external review, which is published on our website, of the research on the efficacy of these products. That review concluded that there was promising work but not conclusive work, so we have commissioned an external review of the medical literature in this area.

Senator STEELE-JOHN: You commissioned a review and, in addition to those recommendations, that was what they relied on?

Dr Skerritt: We paid experts good money for the review, yes. We commissioned an external review of all the research. The delegate also looked at any research that had been published in the period since that review and looked at the submissions; and, most importantly, it took the advice of the Advisory Committee on Medicines Scheduling, which was essentially unanimously opposed to rescheduling.

Senator STEELE-JOHN: 'Essentially'? Was there dissent to that?

Dr Skerritt: As I said, they don't vote, so it's only what you hear at the meetings. They don't work by voting on the—

CHAIR: Dr Skerritt, I'm sorry. Senator Antic, you have the call, and then I'm coming to you, Senator Pocock. We're going to the tea break at four.

Senator ANTIC: This is a question that is for the department broadly. Is it still the department's position that the COVID mRNA injections are safe and effective?

Prof. Murphy: Yes.

Senator ANTIC: It is?

Prof. Murphy: It is, yes.

Senator ANTIC: Can I ask this question then of Professor Kelly? In January 2021, you said the following words in relation to the AstraZeneca vaccine:

In terms of preventing death, it works, 100 per cent of the time. In terms of preventing severe illness, it works, 100 per cent of the time.

Do you still stand by that?

Prof. Kelly: That was at the time and—I think this is very important—at that time, that was the information we had in front of us. Subsequently, it hasn't been exactly 100 per cent, but it has been of very high protection to the point where we have real-world data from Australia. I know that you are in favour of that and I will share it with you. In the current wave that we have been experiencing, the omicron era, since the beginning of this year, in cases with an illness onset from 15 December 2021 to 4 September 2022, the proportion of cases where people have died is more than 22 times as high in unvaccinated people—that would be for any vaccine, including AstraZeneca—compared with fully vaccinated people aged 12 to 49; over 32 times as high in people aged 50 to 69; and over 14 times as high in people aged 70 and over. There's a further halving of the death rate when you get to the third and fourth doses.

Senator ANTIC: Can I ask you this? At the previous Senate estimates hearing, Professor Kelly, you said to me that, in relation to my suggestion that the COVID vaccines don't prevent transmission—which, of course, is a key plank of the mandates—that was 'not a true statement'. It actually was a true statement, though, wasn't it?

Prof. Kelly: No, it was not a true statement, in my view.

Senator ANTIC: In your view or according to the science?

Prof. Kelly: That would be my view based on the science. There is an effect on transmission—

Dr Skerritt: There are several publications on transmission.

Senator ANTIC: There are many publications which say that they have no impact on transmission, so it's not—

Dr Skerritt: And there are many publications that say there's an impact on transmission.

Senator ANTIC: But what is that impact? We went through this last time. What is it in real-world terms?

Dr Skerritt: It decreases. It is lower now with omicron and lower with delta. With the original ancestral and first couple of strains the impact on transmission was significantly greater. It wasn't as great as the impact on infection. On notice, I'm happy to give you a list of seven or eight articles. Quite recently, a study using omicron BA.1 and BA.2 still showed that there was reduced transmission for people who'd had a booster compared with

only two shots, so we're still seeing some impact on transmission. But I need to emphasise, where vaccines have not been approved for an impact on transmission and it is not in the approved product information—

Senator ANTIC: In that case, you would agree, therefore, that the instigation of mandates across the country was a nonsense?

Prof. Kelly: I would firstly say that mandates are no longer the case, from a public point of view.

Senator ANTIC: But they were for 18 months.

Prof. Kelly: There are still some in some workplaces, I will admit. Those mandates were largely an issue for the state and territory authorities and not for us here at the Commonwealth.

Senator ANTIC: Can I just move to a slightly different topic now. Earlier in the day, Senator Waters used the phrase 'pregnant persons' twice and I think, in response, the department used the phrase 'birthing clinics'. Is it the position of the department that men can get pregnant and give birth? I'm sorry to do this to you, but we need an answer. You are the Department of Health and people put a lot of emphasis on this.

Prof. Murphy: To get pregnant and give birth, you need to have a functioning uterus. So, whatever you may call someone, it's generally very unlikely that someone who is a man would have a uterus and give birth. I think that's all we can really say.

Senator ANTIC: So only biological women can get pregnant?

Prof. Murphy: You have to have functioning female reproductive organs to get pregnant and give birth, yes.

Senator ANTIC: Which would limit it to women only, presumably.

Senator STEELE-JOHN: No.

Senator ANTIC: No? Have you ever been pregnant?

CHAIR: Senator Antic—

Senator ANTIC: In any event, I haven't quite finished. I just have another question, Chair. I was actually going to ask the same question of the TGA because, in fact, when the TGA responded to me about a question regarding vaccination in pregnancy, the term 'pregnant persons' was used. Professor Skerritt, do you want to have a go at that one? Does the TGA consider that men can get pregnant and give birth?

Dr Skerritt: I think the secretary has given the biology lesson that you have to have a uterus in order to be pregnant and carry a pregnancy through to full term and, therefore, you have to be biologically female. Different language is used because, obviously, individuals may choose to represent themselves as different from their birth gender. So, that's why we talked about 'pregnant persons'. But I think it's pretty obvious that you need to have a functional uterus to be able to carry a pregnancy.

Senator ANTIC: Minister, if it is ultimately found that there was nefarious conduct with the data, in relation to the safety and efficacy of the vaccines, will the Australian government honour the indemnities given to pharmaceutical companies in relation to any future court action?

Senator McCarthy: I'd like to take that question on notice, if I may.

Senator ANTIC: I thought you might do that.

CHAIR: Was that your last one, Senator Antic?

Senator ANTIC: I could go on and on about that, but I've got a neonatal test for myself; I've got to go and check myself out.

CHAIR: I appreciate the assistance that you're providing to the committee.

Senator ANTIC: I just want to be careful. You never know when a bloke can get pregnant!

CHAIR: Thank you, Senator Antic. Senator Pocock, I'm coming to you. Senator Whish-Wilson wants to place a question on notice and then I'll come to you, Senator Pocock, for your block.

Senator WHISH-WILSON: Just on notice, could give us an update on the number of people—I understand that this would be updated every day by the TGA—who have accessed the SAS or AP Schedule 8 medicinal cannabis scheme?

Dr Skerritt: I'm happy to do that on notice. I could give you an indication. It's about 300,000 for medicinal cannabis.

CHAIR: If you're happy to take it on notice, that would be good, unless you can give it quickly.

Dr Skerritt: It's about 300,000 all-up for the Special Access Scheme for medicinal cannabis products.

Senator WHISH-WILSON: I'll put some more detailed questions on notice. Thank you; that's excellent.

Australian Digital Health Agency

[15:56]

CHAIR: Senator Pocock, you have the call.

Senator DAVID POCOCK: Thanks for your time today, yesterday and, potentially, the day before. I've just got a few questions for the Australian Digital Health Agency.

Prof. Murphy: Chair, it's 5 am in Dublin and we would like Professor Skerritt to be able to go to bed. Are there any more TGA questions?

CHAIR: I will confirm that in the tea break. I understand that we've got about one minute before we get to the break. I'm doing my best to release you, Professor Skerritt, and I will get some advice to you as quickly as possible.

Dr Skerritt: Thank you.

Prof. Murphy: Thank you.

CHAIR: Senator Pocock.

Prof. Murphy: In relation to the Digital Health Agency, we'll get the experts to the table.

Senator DAVID POCOCK: To start with, I'm interested in whether you know how much the My Health Record system has cost to date.

Ms Cattermole: There are probably several elements to the question, because the My Health Record system is sort of part of a national digital health infrastructure that we've been running for a decade now. I can sort of provide you, if you'd like, with the broad elements of what that looks like roughly. It's hard to sort of disaggregate exactly all the pieces, but I can walk you through—

Senator DAVID POCOCK: If you want to take it on notice and just send through the info, that would be great.

Ms Cattermole: I can happily do that. I can give you the sort of broad brush but, given the time, I'm happy to take it on notice. The My Health Record has a number of elements around it, including authentication processes and clinical terminologies, that together make up the system. I can do that now or I can do it on notice, given the time.

Senator DAVID POCOCK: On notice is fine.

Ms Cattermole: Thanks, Senator.

Senator DAVID POCOCK: It is my understanding that, when it was set up, one of the things that was talked about was how it would be useful in an emergency situation.

Ms Cattermole: Yes.

Senator DAVID POCOCK: Do you have stats on what percentage of ED doctors are actually looking at records on the My Health Record?

Ms Cattermole: I do, indeed, and thank you. That's exactly right: that is, indeed, one of the things we've seen and we're seeing it more and more as, sadly, we've been facing a number of emergencies in recent years; we're starting to see that use and uptick. I can take you through some specifics and then provide you with more detail, as you wish.

Senator DAVID POCOCK: That would be great; thank you.

Ms Cattermole: If you take, for example, the Lismore floods or things like the moment the Queensland border opened, the uptick in the use and viewing of the record—for example, by pharmacists who needed to support people who may not have had their medications information—went up exponentially at those moments to sort of 400 per cent and 500 per cent. So it upticked at the moment that it was needed and then moved back to more normal levels once that emergency was not there. More broadly, over the last two and a half years, given the circumstances that we've had with the pandemic, we've seen exponential growth in the viewing use of the record not only by consumers but also by clinicians right across the health system, and that's quite sustained. We've seen consumers, for example, up by sort of 200 per cent and GPs up by 140 per cent. I can give you more detail, but we've certainly seen that emergency environment has created a significant shift.

Senator DAVID POCOCK: Do you have the percentage of visits to the emergency department where the doctor is looking that up?

Ms Cattermole: I've got public hospitals and so, yes, that's a pretty good proxy. Certainly, about 95 per cent of public hospitals are registered for the record. I'm sure that I can quickly find you exactly what the percentage is in use. Year on year, in terms of viewing of the record, public hospitals are up 160 per cent.

Senator DAVID POCOCK: Starting from?

Ms Cattermole: I'd have to take on notice, I think, where they were before. I've got some raw numbers for you, but the raw numbers can be a bit hard, because they're just humongous. For example, there was a viewing of 1,700,000 documents over the last 12 months. They're hard to get hold of.

Senator DAVID POCOCK: I'd love to know the proportion of just how many—

Ms Cattermole: What does look better is the percentage increase, and that's because you can see it.

Mr McCabe: We've seen 22.2 million views in the last 12 months, which was up from 8.6 million views in the previous years in the public hospital context.

Senator DAVID POCOCK: I appreciate the numbers, but I guess that I'm interested in this: for every 100 visits to emergency, how many of those patients have their—

Ms Cattermole: I'd have to take that on notice.

Senator DAVID POCOCK: That would be great; thank you. The other thing I'm interested in is diagnostic imaging providers.

Ms Cattermole: Yes.

Senator DAVID POCOCK: Having a look on the website, I can see that only two providers in the ACT are registered on the My Health Record. Do you know how many are registered nationally and are being integrated into the system?

Ms Cattermole: I've certainly got some increases here. I'll just see if I can give you diagnostic imaging providers.

Senator DAVID POCOCK: Chair, how am I going for time?

CHAIR: Senator Pocock, you have a few minutes in your call, but we'd be grateful if you were as efficient as you could be.

Mr Creech: In relation to the exact number of diagnostic imaging providers that are uploading, I'll take that on notice. The thing that we need to keep in mind, though, is that proportionally a significant number of diagnostic imaging providers are registered and connected with the My Health Record. They don't always upload, though, and that is one of the issues that we are and have been working through over a number of years. We're working hard at the moment to drive that use specifically with the providers themselves. It's the same as with pathology. Uploads are lower than we'd like; they are growing and have grown significantly over the last few years, especially during the COVID period, but not as significantly as with pathology. With pathology, it has really boomed in the last couple of years. But DI has a little bit of work to go, and we're looking to get as many of those into the system as possible. Especially in the ACT, there are two providers that don't upload as much as we'd like.

Senator DAVID POCOCK: I'd love, just on notice, any sort of information that you can give us to try to—

Ms Cattermole: Yes. I've got them here but together, so I'll disaggregate them for you.

Senator DAVID POCOCK: Thank you. Finally, because I know that we're running very short—

CHAIR: No, please, Senator Pocock.

Senator DAVID POCOCK: I'm just wondering what progress is being made in getting rid of fax machines in healthcare; is there an end in sight?

Ms Cattermole: An excellent question.

Senator DAVID POCOCK: I note that a few coronial inquiries have actually pointed out that fax machines were a contributing factor.

Prof. Murphy: It is a really big challenge. Doctors are one of the last bastions of the fax machine and mainly because secure electronic imaging was the issue, and I think that's what we've all been working on.

Mr McCabe: I think it's probably worth saying that, in the health system, there are probably areas that are getting better. For example, primary care or general practice is probably reducing dramatically the use of fax machines. But we've got to do a lot more work in areas like specialists, who don't tend to use as many digital platforms as we'd like them to. So, it's an area of focus in specific areas.

Senator RUSTON: Senator Pocock, I've heard on very good authority that they've got to get rid of fax machines but at the same time they've got to write legibly.

Senator DAVID POCOCK: Thank you. Perhaps you could provide on notice the percentage of GPs or other providers who are still using fax machines?

Prof. Murphy: I think we can certainly provide something on the proportion of GPs who are now fully—

Senator DAVID POCOCK: And potentially, given the coronial findings, whether there is a strategy to find a secure, acceptable and workable way to do it all?

Prof. Murphy: Yes.

Therapeutic Goods Administration

[16:04]

CHAIR: Thank you very much for assisting the committee. We have two senators with two minutes for you, Dr Skerritt, and then we will go to whatever we choose to call the snack. So we're going to have a couple of minutes from Senator McGrath and a couple of minutes from Senator Roberts, and then you should be able to leave. Thank you.

Senator McGRATH: I have two questions in relation to the review into paracetamol. I'm speaking on behalf of my constituents in Queensland, especially rural and regional constituents. The first question is: won't the proposed restrictions unfairly impact on patients who require genuine pain relief and use paracetamol safely and appropriately? A particular element of that is that one of the options is to make modified release paracetamol 'prescription only'. In rural and regional Queensland, it takes some time to get an appointment with a GP; it can take anywhere between one to two weeks and sometimes three weeks. How can those constituents of mine access appropriate pain relief; and aren't they being unfairly impacted by these proposals?

Dr Skerritt: I think we need to clarify the word 'proposal'. Can I emphasise that TGA has no preferred option. Normally, with medicine scheduling, an option is put up and we receive feedback on it. What we did here, based on this independent report that looked at the consequences of 50 deaths a year due to paracetamol, was to put up a range of possible options without showing any preference in order to get feedback on them. So, we are not championing any of those options; we're wanting to get feedback on them. Yes, if you have to go through a doctor, it's an additional step. But that's only one of a number of options and, of course, we've put forward no change to that option as well as to others.

Senator McGRATH: The panel that you commissioned—as part of, I think, the seven recommendations—made several non-medication related recommendations. How would you be planning to implement those recommendations, if you were to adopt them?

Dr Skerritt: The non-medication-related recommendations are beyond TGA's remit, but the panel as well as my senior colleagues at TGA have worked closely with Ruth Vine and others in the mental health area to look at whether and how some of those options could also be implemented. But, of course, our role is in regulating medicines, so that's why the consultation put forward the medicine related options without expressing a preference for any of them.

Senator McGRATH: I do have a lot of other questions but, in the interests of time, I will hand back.

CHAIR: Senator McGrath, we appreciate your cooperation. Senator Roberts.

Senator ROBERTS: I asked a question earlier, Professor Skerritt, about the number of drugs approved under the full approval process, the normal process. If you exclude the number of drugs that you said were new uses for existing drugs and medical devices, what is the figure for new drugs approved under the full approval process in the last three years?

Dr Skerritt: It will be about 90, but I'll give you the exact answer on notice. We approve between 30 and 40 new drugs a year.

Senator ROBERTS: You also confirmed your view that 'the trial data contained sufficient proof that the vaccines were safe and effective, sufficient to meet the criteria for provisional approval'. Yet after 18 months and analysing the data, some of the world's leading virologists and pharmacologists from UCLA, Stamford and here in Australia found that the 'Stage 2 and Stage 3 trial data showed the vaccine was associated with a 36 per cent increase in serious adverse events' and 'out of every 10,000 people injected, 18 will experience a life-threatening or altering complication, and the vaccine should not have been approved, as it caused more harm than it prevented'. That's what they said. One of the papers—there are several papers—is titled 'Serious adverse events of special interest following mRNA COVID-19 vaccination in randomised trials in adults'. How could ATAGI review the data and conclude that everything was fine, with the world's leading experts on the subject, in a peer

reviewed and published paper, then finding the exact opposite? Did you approve the vaccine in a deal with colleagues in the pharmaceutical industry?

Dr Skerritt: I think that's an offensive allegation, and we certainly did not.

Senator ROBERTS: You had colleagues in the pharmaceutical industry.

Dr Skerritt: We did not approve the vaccine in a deal with colleagues in the pharmaceutical industry.

Senator ROBERTS: You had colleagues in the pharmaceutical industry.

Dr Skerritt: I wouldn't say that they were colleagues; we work with people. We also work with—

Senator ROBERTS: That's what I mean: you worked with them.

Dr Skerritt: people in terms of the courts, including the criminal court. So, we work with people in the pharmaceutical industry and we work with other government people, but they're not colleagues in the sense of working for the same organisation.

Senator ROBERTS: Did you do a deal or come to an arrangement with the—

Dr Skerritt: No.

Senator ROBERTS: It could have been just provisional approval to get it through. Did you do that with the pharmaceutical industry?

Dr Skerritt: No. No, that's an offensive and unfounded allegation, and I'd like you to withdraw it.

Senator ROBERTS: There are thousands of people who are dead, and we'll get on to that in the next session.

Dr Skerritt: I disagree with you. There are 14 deaths associated with vaccines in Australia, all—

Senator ROBERTS: We'll get on to that in the next Senate estimates.

Dr Skerritt: I look forward to it.

Senator ROBERTS: Yes, so do I.

CHAIR: Thank you, Senator Roberts. The minister has an explanation that she's seeking to—

Prof. Murphy: Can Professor Skerritt go to bed?

CHAIR: Yes.

Senator ROBERTS: Good morning.

CHAIR: Minister McCarthy, please make your statement.

Senator McCarthy: Earlier today, Senator McKenzie asked me a few questions in relation to a wet lab in Mildura, a project with Southern Cross University to train allied health professionals, a clinic in Coffs Harbour and a partnership between La Trobe and Goulburn Valley Health in Shepparton to train the nursing workforce. I've been advised that these are election commitments of the former government. These projects were not appropriated in the budget but rather were commitments made throughout the federal election campaign by the now opposition.

Prof. Kelly: Chair, perhaps I could just add very briefly a response to one of the things that I took on notice from Senator Roberts.

CHAIR: Yes, please. While you do so, Professor Kelly, if the NHMRC are still in the building, can they just make their way to their chairs because, when you've finished, there will be two minutes for them.

Prof. Kelly: In answer to your question about whether the International Health Regulations were a treaty, I've been informed that they are a treaty to which Australia is a signatory. I would also like to state formally that it does not overrule any Australian law but, in fact, has helped to strengthen our pandemic response throughout the last three years. Thank you.

National Health and Medical Research Council

[16:12]

CHAIR: Senator Canavan.

Senator CANAVAN: Very quickly, thank you for referring back to the NHMRC. In the *Gain-of-function research review* report—I've had a look at it—you haven't actually outlined the 17 papers. You're saying that you can't provide them, because of 'potentially serious threats to the personal and professional lives of scientists'. Are there specific threats? This seems remarkable. This is publicly funded research, involving potentially very serious risks to the public. Why can't the public know what was funded by the public into infectious agents?

Prof. Kelso: During the pandemic, a number of people, working generally in virology and related topics as researchers around the country, have received serious threats and had their lives threatened.

Senator CANAVAN: Did any of the researchers in these 17 papers receive threats?

Prof. Kelso: I don't know the answer to that.

Senator CANAVAN: Take that on notice. I find this totally unacceptable. Could you take on notice from this committee what those 17 reports were. Keep in mind that, obviously, you would need a public interest immunity to not release it. This is publicly funded research. This type of research involves infectious agents that potentially—I do not accept the rationale you gave before—created coronavirus. It's definitely a credible theory that this came from a lab involving gain-of-function research, and I think the public deserves to know where its money is going on potentially risky research. You cannot be laws unto yourselves; and this review, to me, smacks of the fox looking after the henhouse here. You're reviewing your own research, and the report is very defensive. Finally, can I also ask: did any of these 17 reports involve research on infectious agents that may increase pandemic potential or cause it to acquire pandemic potential?

Prof. Kelso: I'll take the question on notice, because I don't have the details with me. They were identified as ones of concern precisely because they fitted that definition amongst the 6,000 or so projects on infectious disease in Australia which, just because they were on infectious diseases, were in scope for analysis. There were 17 that fitted the criteria.

Senator CANAVAN: Just to be clear, I'm drawing this distinction: in the report—I might not be using the correct terms—you said that there was research involving infectious agents which could cause harm to humans; and I believe that there was a 'subcategory', if you like, of research involving infectious agents that could create a pandemic effectively. My question there was especially about whether any of those 17 involved infectious agents that could cause a pandemic.

Prof. Kelso: That was the criterion for analysis: that could cause harm to humans.

CHAIR: Thank you, Senator Canavan. We will be breaking for a tea break. I am just going to formally advise that all agencies listed under outcome 1, excluding the COVID-19 Task Force—

Prof. Murphy: There is no agency called the COVID-19 Task Force.

CHAIR: I'm sorry. I'll read out the list that I have.

Prof. Murphy: Yes. I know that the COVID-19 Task Force was listed as an agency by the secretariat, but there is no such agency. We have a range of COVID-19 functions, so the department can answer questions.

CHAIR: They can answer under outcome 1, Policy?

Prof. Murphy: We don't have ATAGI here, but a senior official who looks after ATAGI can answer questions on their behalf.

CHAIR: In that case, all the agencies are released; thank you. We will be returning to outcome 1 questions for the department when we resume after the break. We will now suspend. Thank you very much. Thank you for your cooperation, senators.

Proceedings suspended from 16:16 to 16:27

Department of Health and Aged Care

CHAIR: For the assistance of those in the room, we have dealt with agencies listed under outcome 1. We will now be dealing with the various program items under outcome 1. We still have Senator McCarthy at the table. I am going to go to the coalition for the call. Senator Rennick.

Senator RENNICK: I'll start with you, Professor Murphy, since you're the only one there. I just want to follow up on Professor Skerritt's comments. Last estimates, back in early April, Professor Skerritt said that the lipids used in the vaccine were the same lipids you have for breakfast. He's now just said there are four different types of lipids and they've been subject to genotoxicity studies. In the actual assessment report it said that there were no genotoxicity studies done on the vaccine whatsoever. We've had this conversation before. I have a trust problem when at the last set of estimates I'm told, 'There's nothing to see here. They're just normal lipids.' Now I'm told there are four different lipids. On the Pfizer website itself they talk about creating a new lipid in record time. I have a serious trust issue here with Professor Skerritt constantly saying one thing and then that changes. Why should I trust Professor Skerritt when he says one thing and then another? He says two different things at two different times. He's changing his story all the time.

Prof. Murphy: Is there a question there or is that a statement?

Senator RENNICK: Maybe it's a statement. Let's move on to the next one. The other night I asked you about blood tests and donating blood after three days. You said there's no reason why the spike protein would be in the actual blood. Firstly, in the actual non-clinical evaluation report from the TGA it says there is no actual testing of the spike protein in the clinic itself. To say that you wouldn't know that it's in the blood—you wouldn't actually know that because, as it says here, there is no distribution and degradation data on the S-antigen encoding mRNA, that is, the spike protein. The same question to you. The other night you said, 'It wouldn't be in the blood.' My question to you is: how would you know that if there is never any testing done on the spike protein, firstly? A study published in May 2021 documented for the first time that S-proteins were found in 11 of the 13 subjects as early as one day after the injection of, in this case, the Moderna vaccine.

Prof. Murphy: Where?

Senator RENNICK: In the blood. They found the spike protein in the blood. Studies have found spike proteins in the blood as early as one day after the actual vaccine.

Prof. Murphy: All I can say is that I'm happy to take that issue on notice again and get Professor Skerritt to respond on the full dataset that we have around this issue. I've not seen any evidence that spike proteins are detected three days after vaccines in any studies that I've seen. But I'm not across all of the literature. If it's a legitimate question I will get the TGA to address it.

Senator RENNICK: You wouldn't find that evidence because there were no studies done, according to this TGA report. Absence of evidence is not evidence of absence. They are two separate things.

Prof. Murphy: We don't know what evidence there is now. We've had now billions of people across the world vaccinated with these mRNA vaccines. You would think that there might be some evidence now. But let's take it on notice and we'll come back to you.

Senator RENNICK: Let's go to another statement that's been made throughout the vaccine rollout, namely, that the vaccine is injected into your arm and it stays close to the injection site. Granted, according to the distribution studies provided in the TGA non-clinical report, a lot of it did stay near the injection site. However, a lot went to other body organs. As a matter of fact, it went to numerous body organs, including the ovaries, spleen, liver, lung, brain, eyes, heart and the injection site, and in many of these organs it was still increasing after day 2. The lipid concentration had increased from day 1 to day 2, and the studies have stopped. I cannot believe that you would stop a study after two days if the concentration of lipids was still increasing in the body organs before you rolled it out, because you would need to know just how high the level goes, how long it plateaus and how long it rolls out and exits the body. Again, how can you justify saying that the vaccine stayed close to the injection site—and this TGA non-clinical report was prepared I think late December/January 2021—and yet many medical experts, including I think yourselves, said it stays close to the injection site, when it didn't?

Prof. Murphy: I certainly didn't say that, but Professor Skerritt may have. We've let him go now. Again, we'll take it on notice to come back to you on that issue. I have really strong confidence in our regulatory process. We now have real-world evidence of many billions of doses of these vaccines. We believe that they are incredibly effective and incredibly safe. Professor Skerritt said we only had I think 14 confirmed deaths associated with vaccines, and many of them were with AstraZeneca. I really do have great faith in our regulatory system.

Senator RENNICK: So did I until this particular rollout. Have you actually read the non-clinical evaluation report?

Prof. Murphy: No.

Senator RENNICK: I strongly recommend that you do. I want to raise a sentence that was on the top of page 8, which talks about the S-protein, which obviously goes inside the cell and is processed by the ribosome. It stated that this suggests the S-protein is synthesised and processed within the endoplasmic reticulum for surface expression or secretion. I thought the purpose of a vaccine was to destroy the foreign body that enters your cell, and yet this seems to be suggesting that the vaccine will go into cells and then the protein created can either be put onto the surface of the cell, namely, the membrane, in which case you will induce an autoimmune response to attack your own cells?

Prof. Murphy: To attack that protein.

Senator RENNICK: Which sits inside the membrane, on the membrane of the cell. It's obviously going to be taking out the cell; the T-cell will kill—

Prof. Murphy: Not necessarily. It's a highly specific immune response to that protein. It's not against the whole cell wall. It's against that spike protein.

Senator RENNICK: That's fine, but that was never tested. We don't know whether the body's immune response takes out just that spike protein in the membrane or takes out the entire cell. You don't know that, because it says here you didn't do any testing of the S-protein, the spike protein. That's step one. This is what concerns me. The spike protein can secrete from the cell and then go back into your body. We'll never know this, because it was never tested. That could potentially lead to clotting or it could lead to other issues if it starts to flow throughout the body.

Prof. Murphy: If that were the case, with many billions of doses given, we would have very good evidence of those adverse effects, and we don't have that.

Senator RENNICK: Let's come back to the rise in diabetes, which is an autoimmune disease. That has risen by 20 per cent. We have had a rise in dementia. You might have the small spike protein going through your body and getting into your brain. There is evidence that would warrant what I would call a red flag. I believe that the TGA, yourself and the department of health should be looking at these increases in deaths. As I said, the two biggest causes of dementia, which suggests that's the spike getting out into the bloodstream, or diabetes, which is an autoimmune disease. That could be creating some problems. Potentially, problems that should be examined closely.

Prof. Murphy: We don't have any evidence of association between vaccination, diabetes or dementia.

Senator RENNICK: But you had signals. The whole point of having a TGA database is as a signal, ultimately. I'm not going to say that every report is definitive proof of vaccine injury. But you've had such a spike, and I'm talking about rate of injury. Obviously, when 20 million people take it in six months you're going to expect some sort of spike. I'm talking about the rate of injury, and that is a red flag.

Prof. Murphy: There's a rate of reported adverse events. After careful examination, the rate of actual injury is very low. As Professor Skerritt said on many occasions, every one of those reports of associated symptoms is not evidence of injury. I do think, Chair, that we perhaps should have explored this with the TGA, and I would prefer—

Senator RENNICK: With all due respect, he should have been here.

Prof. Murphy: We asked permission for him to go to bed, because it's five o'clock in Dublin. The committee agreed to do that.

Senator RENNICK: I meant to be here in Australia for these estimates; I would have thought it's his duty in terms of accountability. I'm not having a go at you, Chair.

CHAIR: I thought your questions could be answered here.

Senator RENNICK: So do I. I think these guys need to take responsibility for the performance of the TGA. Like I said, this is not about you, Chair.

CHAIR: It's coming to the end of your 10-minute block. Are you happy for me to pass on the call?

Senator RENNICK: Yes, absolutely.

CHAIR: Senator Ruston.

Senator RUSTON: Earlier today the Premier of Queensland announced that the state of Queensland was moving from a green to an amber alert in relation to a spike in COVID cases. Have you provided any advice to the Queensland government in relation to that decision?

Prof. Kelly: No, I've not provided advice to the Queensland government. They have a Chief Health Officer who provides that sort of advice. Their amber designation is very much based on the community protection framework, which was announced and made public on 14 October. That was an agreed position of the AHPPC, of all the Chief Health Officers and myself, and also by the first secretaries on behalf of National Cabinet. I'm happy to table that, if you haven't seen that document.

Senator RUSTON: I understand from communications that there has been an indication that no actions are required today; is that your understanding, that an amber alert doesn't require any enforceable mandated actions?

Prof. Kelly: Not enforceable mandated actions, but as per the community framework it would be equivalent to tier 1. When the first copies come back, you'll be able to see why that is. Essentially, it's an alert particularly in Queensland for their healthcare workforce. Mask use is one of the key components of their amber. It's also further advice to the general public about what they could or should do in relation to the current wave. And we are in a wave right now, including in Queensland.

Senator RUSTON: Am I to assume that the documentation that you've just provided is likely to give me the breakdown of what happens at different stages?

Prof. Kelly: Yes, that's correct.

Senator RUSTON: I'll wait for that to come back before I ask any more questions around that. When the decision was made to end mandatory isolation rules a couple of months ago, did you provide advice to National Cabinet to that effect?

Prof. Kelly: Again, I'm happy to table the document. I was requested by the Prime Minister to provide advice on the day before National Cabinet, and he shared that with his colleagues in National Cabinet. That was subsequently made public.

Senator RUSTON: Did you consult with the AHPPC before you provided that advice?

Prof. Kelly: I was asked by the Prime Minister to provide advice to him on the day before National Cabinet, and I did so.

Senator RUSTON: I absolutely heard you say that, but I just wondered, did you actually consult with the AHPPC in relation to the advice you are going to be given?

Prof. Kelly: I did not, because of the time period.

Senator RUSTON: You would normally speak to your state counterparts, but it was the time frame that you're saying is the reason why you were unable to do so?

Prof. Kelly: Yes, that's correct.

Senator RUSTON: It would immediately make me jump to the conclusion that the advice potentially could have been rushed, given the time frame. In your expert opinion, do you believe a day or two would have been able to provide you with the opportunity to be able to better consult on your advice with your state and territory colleagues?

Prof. Kelly: I was asked by the Prime Minister to offer my advice to him in relation to this matter, and a few days wouldn't have changed my mind.

Senator RUSTON: There was no instruction not to consult, you just chose not to?

Prof. Kelly: There was no time to do that. I'll table my statement as well, so it can be in front of you. There is consideration there of the reasons why at that time, in the context that we were in in the pandemic, that was an appropriate decision to be made. The proof of the pudding is what we've seen; it did not lead, as some people have suggested it would, into a major increase in cases over the weeks after that time. The other key part of that advice, when you get to read it, is that was very context and time specific. The key component was eternal vigilance to make sure that, when we entered into a new wave, we were able to recognise that and alert the public, similar to how the Chief Health Officer and the Premier in Queensland have done today.

Senator RUSTON: Minister, could you give some advice as to when that National Cabinet meeting was called?

Senator McCarthy: Sorry? Are you talking about the previous National Cabinet meeting?

Senator RUSTON: I'm asking about the meeting that Professor Kelly provided the advice to.

Senator McCarthy: Why don't you ask Professor Kelly. He provided that advice to that particular—

Senator RUSTON: No, I wasn't asking about the advice. I was asking about the timing of the calling of the meeting.

Senator McCarthy: That's what I'm saying. If you're asking about when he provided the advice—

Senator RUSTON: No, I'm asking you when the meeting was called.

Prof. Kelly: The meeting took place on 30 September.

Senator RUSTON: No, I asked: when was the notification provided that the meeting was to take place? When was the decision made to hold the meeting on that date?

Prof. Kelly: I'd have to take that on notice and consult colleagues in Prime Minister and Cabinet.

Senator RUSTON: Minister, you might like to take that on notice and come back to me and let me know the date the decision was made to hold that National Cabinet meeting. It would be very interesting to know whether the meeting was called on the same day as Professor Kelly was asked to provide the advice, which restricted him having the ability to be able to consult with his state and territory counterparts before giving the advice that he provided to National Cabinet, without consulting his state and territory colleagues, which I would suggest he has done on every other occasion that he has provided advice.

Senator McCarthy: It is a matter for the Prime Minister in regard to National Cabinet, but of course I'll see what we can find out for you.

Senator RUSTON: That would be great. To quote a close colleague of yours, a well-functioning National Cabinet should have been transparent and accountable, with decisions subject to scrutiny and oversight. I would suggest that has not been the case in this instance.

Senator McCarthy: Is that from your health minister or the other health minister who was the previous Prime Minister?

Senator RUSTON: No, that was actually from Minister—

Senator McCarthy: I'm just checking. I know you had two health ministers.

CHAIR: Senator Ruston, you have the call.

Senator RUSTON: I'm just wondering about the defensive response from the minister at the table. It was actually Senator Gallagher who made that statement, not anybody in the previous government. Moving on to the Jane Halton report, where is the government at in relation to implementing the findings of the review?

Prof. Murphy: Many of those recommendations are already in progress, particularly the recommendation that we pursue a portfolio of vaccines. So, that means consideration of further purchases when we've run out, particularly of the Moderna vaccine. The government is discussing that now. That was the principal recommendation from the review. There were recommendations about some of the governance structures, such as how ATAGI functioned in a pandemic, and that process is being looked at now with ATAGI in the department. Government is, I believe, intending to publish a brief response to the draft recommendations later this year, subject to the decision of the minister, and that will probably outline in more detail the progress on the review recommendations. Does Ms Garrett have anything else to say?

Ms Garrett: No, I think that covers it all.

Senator RUSTON: Right now, what's the fourth dose vaccination rate?

Prof. Murphy: I'll get that. I think Ms Garrett has it.

Dr de Toca: As to vaccine policy implementation and response—at the moment, dose 4 coverage for 65 years and over is 74.7 per cent, and for people 50 years and over, 57 per cent. For people 30 years and over, it's lower, at 41.7 per cent, but it's important to remember that ATAGI does not encourage people in the 30-49 year old age group without other comorbidities to get the fourth vaccine. They allow them to receive it if they so choose. But they recommend people 50 years and over to receive them.

Senator RUSTON: So, of those people who are eligible for a fourth dose, how many in total have received it?

Dr de Toca: For those who are recommended, which is 50 years and over, it's 57 per cent.

Senator RUSTON: You're saying that there is no recommendation for people under the age of 50 to have the fourth dose?

Dr de Toca: For people between 30 and 49 years of age, and some other younger people. For the general population, 30 to 49 years of age, ATAGI has a permissive recommendation. If they so choose for their individual circumstances, they can get it, but it's not recommended for that group. There's a small group of younger people, both 30-49 and younger, and that includes people who are severe immunocompromised, have disability, complex health needs and multiple comorbidities, who are also recommended for the vaccine, but it's hard to quantify that number specifically.

Senator RUSTON: Professor Kelly, on the back of the information that Dr de Toca has given us, are you concerned at the rate of fourth dose vaccinations?

Prof. Kelly: In terms of third dose vaccinations, I'm very happy with that rate, particularly in the older age groups. Fourth doses can increase the protection marginally and, yes, I would prefer it was a bit higher, but at the moment, again, in those older age groups, as Dr de Toca mentioned, that's a very high or world-class rate of fourth doses.

Senator RUSTON: You say it's a world-class rate. Australia should be proud of many of the world-class things that we've done through the pandemic. Much of that credit goes to the people sitting in front of me. We've gone to amber in Queensland today. I'm sure that's likely to happen around the rest of Australia. I'm just interested to understand what the government's preparedness is at the moment in relation to responding to what inevitably appears to be another wave of COVID. Is there any proposal to encourage Australians to maximise their protection through vaccination?

Prof. Kelly: It won't surprise you that I have another statement to table. On 7 November, published on the 8th, is a statement from me. I did some media earlier in the week exactly on this topic. It's very important that Australians are aware that there is an increase in cases and that there are some things that people should consider

doing—wearing masks indoors, and if sick avoid going to high-risk places, and to stay at home if possible. If sick and at higher risk of severe disease, make sure that you have a plan to get treatments, which are very effective. Most importantly, if you're due for a vaccine, get that vaccine. They're the points, again, in that framework. That's what we would do in these circumstances. That's what we're doing. My colleagues in the states are also doing the same messaging. In terms of further vaccine doses—and there has been some media around that today—perhaps Dr de Toca can talk to discussions.

Dr de Toca: Yes, there has been a lot of media, which always makes things interesting. ATAGI, the Australian Technical Advisory Group on Immunisation, is continuously reviewing the evidence and the emerging trends in an epidemiological context here and overseas. As part of the regular meetings, it continues to review the booster advice. At the moment, the advice remains that, as you highlighted and as Professor Kelly mentioned, maximising dose 3 and dose 4 coverage for those who are eligible, and dose 5. Some people who are severely immunocompromised are already getting five doses—the primary course is three—and this is the absolute goal. As Professor Kelly said, third dose and fourth dose rates are very high, but there is still a significant proportion of the older population who haven't had it. So, at the moment the advice from ATAGI is firmly to stay up-to-date, which is a third dose for the majority of people 16 years and over, and a fourth dose for people 50 years and over. ATAGI continues to meet. If there's evidence of other requirements to recommend another dose for a particular group or others, that will be taken to government for decision. But that advice has not been provided.

Senator RUSTON: For people who were early adopters because they were in the higher risk categories for first dose, second dose, third dose, fourth dose, what would be the longest time period since somebody who was actually on a program of vaccination would have had their fourth dose?

Dr de Toca: Given the timing of the original fourth dose advice, which back then was called the winter dose—I think it was part of our preparation for winter—there was an ATAGI change made on 25 March. There are some people who are just over or at the cusp of six months from their previous dose. The other important factor here, as we have discussed throughout this session, is that the goal of the vaccination program is to protect from severe disease, hospitalisation and death. Even though we do now have evidence that the protection from transmission and infection does weigh in relatively quickly, because antibody levels go down, the cellular immunity, the immunity that is caused by T-cells and B-cells, provides more prolonged protection against severe disease, hospitalisation and death. We're also seeing that hybrid immunity, mixed immunity from immunisation derived from vaccine and immunisation derived from the virus, also provides a very long and durable response. A series of surveys published a couple of weeks ago showed that at least two-thirds of adults—and that is probably an underestimate—have had COVID recently, probably in the last year, plus high levels of vaccination rates, and this means we have a population with very high levels of hybrid immunity. What ATAGI is monitoring now is, for those particularly high-risk groups who have had a vaccine or an immunising event—infection could be an immunising event—six or more months ago, what the level of protection is and whether additional doses are needed, but we're yet to provide advice.

Senator RUSTON: So, there's been no advice in terms of a fifth dose even to the most compromised in the population?

Dr de Toca: No, there hasn't.

Senator RUSTON: There are a lot of older Australians who probably took great comfort from the protection of vaccinations. When do you think ATAGI is likely to provide advice one way or the other in relation to fifth doses?

Dr de Toca: I can't pre-empt—

Senator RUSTON: I should have asked them.

Dr de Toca: I cannot pre-empt when ATAGI will provide the advice. I can definitely not pre-empt whether there will be advice for a fifth dose at this stage or not. At the moment, ATAGI's firm statement remains that people should remain up-to-date with their vaccination. Based on the evidence that we have, an older person who has stayed up-to-date and has received a fourth dose still has great protection against severe disease, hospitalisation and death.

Prof. Murphy: The other thing to mention, and I think Professor Kelly mentioned, is probably the most important added benefit in a wave like this is to make sure that those fully vaccinated older people have good access to antivirals, which is the next level. We are seeing a very significant uptake, now that this wave has started, in antiviral use. As to antiviral use, since indications were broadened recently by PBAC, we have one of the best antiviral uptakes in the world and we're starting to see that it's one of the best markers we have of the pandemic; once cases go up, antiviral use goes up. If you've had four doses and you're an old person who's

vulnerable, it's probably a more important thing to get access to antivirals than to consider another dose, for which the evidence is not very strong at the moment.

Prof. Kelly: Effectiveness of protecting against death is remarkably high and immediate. We know that people are getting antivirals on average less than a day after they get a positive test. People over the age of 70—this is Australian data—who receive a treatment within one day are approximately 63 per cent less likely to die. There is also a substantial benefit against hospitalisation. That's real-world data from Australia. That's the key message and you'll see that it's a message in my statement earlier this week.

Senator RUSTON: The purpose of my questioning had nothing to do with antivirals. The purpose of my questioning was to understand what information has been provided to government in relation to their portfolio of vaccines and the redundancy measures that get built into it in relation to the procurement.

Prof. Murphy: In relation to vaccines, there are plenty of vaccines. We have a full range of vaccines available. All of our primary care vaccination sites, the vast majority, are still active. People can get access to a vaccine the same day pretty much anywhere in the country now. Pharmacists have stepped up and are now doing about half of the primary care vaccinations. We're keeping all of those points of presence going. I think you did mention communications, which is a challenging issue. We've had a lot of communications around vaccination, but the community is pretty tired of it. Our communications more recently have been focused on the antiviral stuff, and that's shown a benefit. The minister is very keen that we keep promoting vaccinations, but more particularly we keep making it easy, accessible and free.

CHAIR: Senator Urquhart.

Senator URQUHART: The former government released the Primary Health Care 10 Year Plan '22-32. They also published Australia's Long Term National Health Plan in 2019. I'm interested in the funding attached to those long-term plans. What ongoing measures for primary care were funded by the previous government to support Medicare to respond to the increasing pressures on the system?

Mr Cottrell: I can answer part of the question in relation to the Primary Health Care 10 Year Plan. In the published version of the plan, the previous government had a foreword which listed all of the investments that were made towards that plan by the previous government. I can provide you a link to that. I don't have it here with me, but I can provide you with a link to all of that information on notice.

Senator URQUHART: Can you tell me what the funding measures were? How long was the 10 Year Primary Health Care Plan funded for?

Mr Cottrell: Beyond the forward estimates periods, as at the March budget, there weren't any specific commitments. So, for four years from the March budget.

Senator URQUHART: A 10-year plan with no 10-year funding; is that correct?

Mr Cottrell: I think I've described the situation. There were four years of funding commitments.

Senator URQUHART: Four years of funding commitments for a 10-year plan. Did the department provide advice to the government or to central agencies regarding that rationale for providing that short-term funding?

Mr Cottrell: The department provided advice at various times and iteratively to the government about what it might like to invest in in relation to that plan. The decisions taken were announced with that plan.

Senator URQUHART: Are you able to tell me what that advice was?

Ms Rishniw: Senator, as usual, we wouldn't reveal advice to government.

Senator URQUHART: I presume it was to not fund it for just a four-year period but for a 10-year period. Would that be a reasonable assumption?

Ms Rishniw: As Mr Cottrell has indicated, we provide all sorts of advice. In the normal course of budgets, government takes decisions in due course. There were a number of programs and initiatives listed, as Mr Cottrell indicated, in the start of that plan, and it was government's decision in terms of how it would fund—

Senator URQUHART: So it was funded for four years?

Ms Rishniw: There were specific initiatives that fit under the plan that were funded. There were specific initiatives that fit within the reform picture of the 10-year plan that were funded.

Senator URQUHART: But not all of it?

Ms Rishniw: No.

Senator URQUHART: Can I go to just a couple of questions around My Health Record. Can you tell me why digital health is so important to the future provision of health care for Australians? I know we had some questions on this earlier, but I just want to go over a couple of them. Why is that record so important?

Prof. Murphy: It's a critical single point of information. Ms Shakespeare is the expert and she will provide some—

Ms Shakespeare: It's a personally controlled record of health information. The consumer who owns the record and their health data can decide which of their health professionals access it. It has the potential to allow people to allow different providers across different settings to get access to their health information so that they don't have to continually tell each of the healthcare providers all of their medical history. It is very important that we make sure that the records are being used by different healthcare providers. If you've got somebody that's going from hospital back into the care of their GP, potentially in aged care, they'll have lots of different healthcare providers and it's a secure way of sharing health information with all of those different providers.

Senator URQUHART: How frequently is it used? Sorry, I should rephrase that. Is it used by all GPs, health professionals and hospitals? Does everybody have access to it?

Ms Shakespeare: Very large percentages—I think GPs registered and using is above 95 per cent, but I might—

Mr McCabe: It's about 98 per cent for general practice. It's quite significant use. I think it's around 96 per cent in public hospitals, as an example.

Senator URQUHART: Okay. Has My Health Record been adequately funded to deliver on the potential benefits?

Ms Shakespeare: For the current financial year, the amount of money available for the operation for My Health Record—this is through the Digital Health Agency—is 177.7 million.

Senator URQUHART: And what's that been previously?

Ms Shakespeare: In 2021-22 it was 221.2 million. I don't have previous years, but it will have moved around a bit.

Senator URQUHART: Is that sufficient? Is that adequate funding?

Ms Shakespeare: At the moment My Health Record, in terms of the technology platform, I guess, is a library of PDF documents. It's not going to be what we need in the future to allow that objective that I mentioned before about being able to easily share information between lots of different healthcare providers securely. We will need additional investment to make it achieve those objectives and take it from the fairly antiquated platforms it runs on at the moment to something that is going to be truly interoperable.

Senator URQUHART: Okay. Thank you.

Senator STEELE-JOHN: Back in August, the National Cabinet decided to amend COVID isolation from seven days to five. Was this a recommendation given by the department of health ahead of that decision?

Prof. Kelly: That advice was given from the AHPPC—the Australian Health Protection Principal Committee, which I chair and the committee has heard of many times before. It's all the chief health officers and some other experts.

Senator STEELE-JOHN: Yes. But was that a decision that was given to the National Cabinet ahead of that decision being made?

Prof. Kelly: Yes.

Senator STEELE-JOHN: When was that advice provided to National Cabinet?

Prof. Kelly: It was provided as part of the papers for that meeting. Apologies, I don't have the date, but the date you mentioned is the time they met.

Senator STEELE-JOHN: So the National Cabinet then made the decision to remove all mandatory COVID-19 mitigation strategies. Was the recommendation to end the isolation periods recommended by the department of health for their decision?

Prof. Kelly: This was covered by a question earlier when you were out of the room, Senator. There's a paper, which perhaps you could see, which is my letter to the Prime Minister dated the 29 September. That was advice I was asked to give to him and he shared that with his National Cabinet colleagues.

Senator STEELE-JOHN: What risk assessment was undertaken before the National Cabinet made the decision to remove all COVID-19 restrictions?

Prof. Kelly: The circumstances and the rationale behind my advice is mentioned in the letter there, Senator.

Senator STEELE-JOHN: Thank you. I'll take a look through the letter. But I'm not wanting to miss the opportunity to ask you directly: did the risk assessment include projected years of life lost as a part of the calculation?

Prof. Kelly: The advice was based on the circumstances that we had at that time, which was a very low rate of cases in the community, very high hybrid immunity from a combination of high vaccination rates and previous infection, and the fact that we had many other modalities of control. I did very much point out, and this is crucial to the letter, that was context and timing specific. I made this commitment very strongly in the letter. Also, part of the discussion around this decision was that we must continue to look very closely at what is happening in our community and internationally with regard to new variants of concern, increases in cases and, particularly, severity of illness; to alert the public that was happening, if it was happening; and to have a plan about what should happen in those circumstances. So two weeks later, before that change in isolation period came about on 14 October, the Community Protection Framework, which was discussed and agreed by all AHPPC members, came to being, and that's also been tabled in your absence. We can get you a copy of that.

Senator STEELE-JOHN: Thank you. Just to clarify: as part of the advice that you provided or that was provided in considering this decision, did it include an assessment of projected years of life lost?

Prof. Kelly: Not explicitly, no.

Senator STEELE-JOHN: So it didn't include that. Did it include a projected figure around, or did it factor in, the assessment of disability-adjusted life years?

Prof. Kelly: Not explicitly, no.

Senator STEELE-JOHN: That's worrying. How many disabled people have died from COVID-19 in the pandemic so far?

Prof. Kelly: As you know, we've talked about this many times before. I can't tell you exactly that number. I can tell you the number of people that we know who are registered with the NDIS who have died during the pandemic and that number is 196 up to the 30 June 2022. I don't have more recent figures. For people on the disability support pension it is 394.

Senator STEELE-JOHN: Okay. So, before we go to the question of why you can't go to anything more specific than that, in terms of those two figures, is that overlap? Do those two figures overlap or are they distinct?

Prof. Kelly: I believe there would be some overlap, Senator, but I'll take that on notice.

Senator STEELE-JOHN: Can you take that on notice so that we can get—

Prof. Kelly: We do rely on a partner agency. There is overlap.

Senator STEELE-JOHN: Okay, thank you. We've talked about this before, but you do realise, Professor, that there are disabled people who do not access the NDIS?

Prof. Kelly: I do, Senator. I'm fully aware of that. I can only give you the information that I have. I know that our most recent figures for NDIS participants are, again, 280 active cases and 26,706 recovered cases. In terms of workers in that scheme, there have also been 192 active cases and 34,403 recovered cases, and no deaths in that group. But I've already mentioned the deaths, unfortunately, for the others.

Senator STEELE-JOHN: How many people do you approximate have been—I missed in the statistics that you currently have—

Prof. Kelly: I don't think that's an answer that's available to me, Senator.

Senator STEELE-JOHN: Well, it's available to me in terms of—I at least understand, and you will understand, that the ABS collects a set of data in relation to how many disabled people there are in Australia.

Prof. Kelly: Yes.

Senator STEELE-JOHN: Roughly four million. There's a significant gap between that figure and the figure that you've been able to provide me with today, isn't there?

Prof. Kelly: They were numbers of known positive cases of COVID, Senator. So, in terms of the denominator, I haven't used that, but my colleague may have further advice.

Dr Gould: We work with the ABS to link a number of their data holdings, including the census and disability support payments, with their mortality database. Their mortality database is naturally somewhat lagged in terms of our ability to report on it, but through this linked detailed information we're able to get a range of definitions of disability, including identification through the census process as well as disability support information. So we are

able to drill in to a fairly granular level on deaths of people with disability and we can do so at quite granular geography as well. We've got an ongoing program of work looking into that and we could provide you with more statistics around that on notice.

Senator STEELE-JOHN: Minister, we have discussed this topic before in this committee. I've been happy to disclose previously to the former health minister, and I'm happy to do so again today, that I am somebody who is not an NDIS participant and I've had COVID-19 a couple of times now. There are many disabled people across the country that fit into that same category. At the moment, were they to pass away of COVID-19, the Australian government doesn't have a way to count that figure. Is that a problem that the health minister is currently working to address?

Senator Gallagher: I'll have to take that on notice because I don't know what the health minister is—

Prof. Murphy: Senator, I think Dr Gould indicated that's exactly what we've been working on.

Dr Gould: We are working on that information.

Senator Gallagher: I think the point is that the more information and understanding of the impacts of COVID-19, the better. No doubt colleagues here can explain the works underway. I understand the point you make. But I think there are also challenges about how you would collect that data, unless you're going to disclose that in a way that is collectible by the government. I think that goes to some of the challenge.

Senator STEELE-JOHN: There's no doubt at all that it is a complicated issue. The point that I make is that, at the moment, the federal government has, sadly, only a very limited window onto how many disabled people are contracting and suffering consequences, including death, from COVID-19. That absence of data is a huge hole in informing the policy response of the government. Thank you.

Senator RUSTON: Can I now go to the claims that have been made in the media recently around Medicare fraud. Obviously, there's been much made of an $8 billion claim of fraudulent activity by general practitioners in claiming Medicare. I'm just wondering whether the department has met with Dr Margaret Faux about her report.

Prof. Murphy: I might just start and then hand over to Mr McCabe, who has met with her, even before the media allegations. We have not found any evidence to support the size of the claim that was made in the media—the $8 billion claim of fraud and billing errors. We do accept that, with a program the size of Medicare, there are elements of fraud, there are elements of billing errors and there are elements of overservicing. Mr McCabe has a team of 350 people working on that issue. But Mr McCabe met with Dr Faux. We've examined thesis and we find no—it's essentially an assertion not backed by any evidence that we've seen that the issue was that large.

Senator RUSTON: Mr McCabe, following what Professor Murphy's just said, in your investigation of thesis and your conversations with Dr Faux, what would you suggest should be the hypothecated figure or thereabouts of the level of inappropriate claiming of Medicare if it's not $8 billion?

Mr McCabe: Senator, I think it's been reported in the media that the ANAO did an audit on the Medicare compliance program back in 2019-2020. They actually reported a number that ranged from $266 million up to about $2 billion of potential noncompliant claiming of Medicare. I guess an element of that would include inappropriate practice at a very high end and small—high-end in terms of concern there would be some fraud in that number as well.

Senator RUSTON: It's a very large scope—$266 million to $2 billion. I'm just interested in what the department's response has been to these claims. Has the department made any response to it?

Mr McCabe: The minister has—

Senator RUSTON: I know what the minister's done.

Ms Shakespeare: So just in terms of those ranges, it's based on information that's been provided to us by different consulting groups that have looked at fraud in similar programs—fraud and inappropriate claiming, I think. There are US programs—Medicare and Medicaid. I think the most recent report I saw about their programs estimated six per cent. Some of the Boston Consulting Group McKinsey assessments that we had done for Australia suggested between one per cent and four per cent. It was six per cent in another report, and three per cent and five per cent. So that's why there is a large range. I just wanted to explain the context behind those figures. In terms of the department's work, we have an ongoing program of compliance. It's probably quite similar to other public regulatory functions in that we apply a regulator pyramid approach. We think most of the inaccurate billing is not deliberate; it's mistakes. Our approach there is to try and bring people who are not billing in a compliant way into compliance. So that's a range of education programs. I can get my colleague to talk a little bit more about that.

Senator RUSTON: Unfortunately, we don't have time.

Ms Shakespeare: They become more targeted as the conduct becomes more serious. So, certainly, if there's inappropriate practice or fraud, we have very strict approaches to managing those. Fraud is a criminal offence, and we work with the Director of Public Prosecutions about those.

Senator RUSTON: I don't mean to be—I'm going to have to ask you to shorten your answers, because I know the chair is going to be down on me like a tonne. If you could provide me with details around what other compliance activities—I don't need it now; you can provide it on notice—and efforts the department undertakes. Obviously, the PSR is the body charged with this particular issue, but I'd be keen to know what other compliance activities the department undertakes in addition to the PSR's work in relation to compliance.

Prof. Murphy: Senator, I would also say that, because public confidence, potentially, has been affected by these media claims, Minister Butler has also commissioned an independent review with an expert economist to have a look at Mr McCabe's processes and systems to provide assurance to government and the public that our compliance system is robust.

Prof. Kelly: It's probably also worth mentioning that as part of that review we're having a look not just at the compliance program but also at whether there are any issues up-front in Medicare that might need tightening up in terms of how it's used; and also looking at the integrity of all the payment channels just to make sure that, if there are any potential gaps, they're closed as well.

Senator RUSTON: Yes. One of the other things that these media claims have made is that the department is not able to interrogate data and detect fraud. Do you have a comment on that?

Mr McCabe: No, I disagree with those media claims. We do detect small numbers of fraud cases but obviously worth lots of money as well. I think in the last financial year we dealt with upwards of 16 matters before the courts, which resulted in over $24 million worth of matters being prosecuted through the courts.

Senator RUSTON: Obviously, it's completely incorrect to characterise the department as being impotent when it comes to compliance enforcement. Great. Have you completed your review, Mr McCabe—the one that the minister sought for you to do internally?

Mr McCabe: The minister asked for two pieces of advice. One was a broader background one to explain all the things we do in compliance, and I think we just talked about some of that today, but also some advice on Dr Faux's PhD, just to really contextualise what's in that PhD and try to relate it to the allegations that have been put out there in the media. I think it's important to note that the PhD, as we've reviewed it, talked about potential noncompliance in the order of $1.5 billion to $3 billion and talked about how most of the noncompliance related to doctors not understanding how to use Medicare. So the narrative in the media is quite different to what's actually in the PhD.

Senator RUSTON: So, as to those two pieces of work that the minister commissioned you to do, has the minister received them?

Mr McCabe: The minister has received them.

Senator RUSTON: Have they been made public?

Mr McCabe: No, they haven't.

Senator RUSTON: Do you know whether there's the intention to make them public? Minister, do you know whether there's any intention to make that information public?

Senator Gallagher: He's certainly spoken about the report he's received, which I think has led into this independent assurance review that's happening. I'll take that on notice and come back to the committee and see what information we can provide. It may be that information is going to feed into this review somehow and maybe it's not the right time to release it, but I'll take it on notice.

Senator RUSTON: That'd be great. Certainly I have heard stories of the significant impact on medical practitioners, particularly GPs, of these stories. Have you had similar correspondence that would indicate that a lot of GPs out there are finding these kinds of reports extremely distressing?

Prof. Murphy: Certainly the peak bodies, the colleges of GPs and the AMA, have reported to us—we have regular engagement with them—that they find these media reports distressing and concerning. So they've certainly reported that on behalf of their members.

Mr McCabe: The other thing to mention briefly is that I've had a number of approaches from professional bodies and clinical colleges saying, 'It would be timely for you to come and talk to our members about compliance and the risks that we have to deal with in Medicare as well'.

Senator RUSTON: The other one that we've heard anecdotally at least is that we've had practitioners that are resigning or considering resigning or retiring as a result of this—particularly the retirements. Have you had advice to that effect as well?

Ms Shakespeare: We're happy to check what correspondence we have received. I can't answer that question now, but we do get a lot of letters from individual doctors, so we can check our records for you.

Senator RUSTON: Finally, has the department done any communication that would, I suppose, alleviate this level of anxiety and concern that obviously has been generated by this, to make sure that the overwhelming majority of our medical practitioners, and GPs particularly, know that we know they're doing an amazing job and that the government and the department believe that this 30 per cent or $8 billion claim is unfounded?

Ms Shakespeare: We've been asked about this by a number of different media news outlets, and we've provided information back to them along the lines that we've said to you today.

Prof. Murphy: Minister Butler did include in his media release about the independent review statements that the department had found no evidence to support the scale of the fraud. So he made a statement to that effect.

Senator RUSTON: Okay. Obviously, it's very concerning when we've got the GP crisis that we have at the moment that we've got a situation where our GPs are under threat. Can I move back to the hospital funding that we were discussing a little earlier today. I'm just quickly touching base back on the discussion around the national health reform money. We'd established that the $2.372 billion was on the basis of the activity funding model. Then I put it to you, the other colleagues and the funding authority, and your response was that there was another table on page 17 that actually showed an increase in funding. That included—in that other funding was also health infrastructure, which clearly is not about hospital services. It had Indigenous health in there, which obviously goes by a different pathway. So, even accepting that there has been an increase in the other table, we still have a $1.14 billion decrease in payments to the states and territories over the four years. I would put to you that this variation isn't contained anywhere else in the budget. So, if you're able to provide me with alternative information that corrects what I'm thinking, as I'm sitting here today on the advice that you gave me before, the net impact on payments to states and territories, with the exclusion of COVID funding and infrastructure funding, would still be well in excess of $2 billion.

Mr Exell: Can I just check your figure. You're drawing a comparison from the previous estimates—

Senator RUSTON: From March until October. Is there something that's happened between March and October that would have changed that?

Mr Exell: I note that, in the table we provided, on page 17, the top line is the national health reform funding, which actually does show the increase that we talked about. The bottom lines or the lines under that are additional payments on top of that. So I think you can see the increase that's based upon the advice that comes from states and territories. Page 18, the next page, actually goes to the advice provided by those states and territories and gives the forward projection that lets us build, and the footnotes that are in Budget Paper No. 3 actually go to and specifically draw out the uncertainty, given the change of patterns on activities over the previous year.

Senator RUSTON: You weren't here, and I don't know whether you were listening this morning, Mr Exell. I acknowledge the fact, because of the activity base of the funding, that there was every likelihood I could explain why the reform agreement was as it was. I was just seeking to understand why there was no provision made elsewhere in the budget. I'm more than happy to prosecute this until the cows come home with you, because, no matter which way you look at it—and you can talk about changes in parameters and the like—there is still definitely not as much money in the budget for the states and territories as there was in March.

Senator Gallagher: Can I just jump in there—

Senator RUSTON: Well—

Senator Gallagher: No, I think I need to respond. In terms of government decisions, where government makes a decision, there are additional funds in the budget. In terms of the states and territories sending an invoice and us paying a cheque, that has varied because of less activity. So let's just be clear about that.

Senator RUSTON: I'm very clear about that, Senator Gallagher—very clear. That was not the questioning this morning. You weren't here for it. I was just trying to understand why provision hadn't been made for a known increase in activity. I accepted the fact that you said that it's activity-based funding. But, anyway, could I just move on. I'm happy to provide more questions on notice and you could provide me with some more details, because they are particularly complicated and confusing for somebody who's not an accountant. In the next financial—in this current financial year, there's some ongoing COVID funding, and there's been a change since March of an additional $886.3 billion that's gone to the states and territories in relation to COVID funding.

Prof. Murphy: Million, I think.

Senator RUSTON: Sorry—$886 million. They'd be really lucky. Millions; billions. It is $886.3 million of additional COVID funding made available to the states and territories subsequent to the March budget. Could you advise what the basis of that additional funding is?

Ms Essex: I think what you're referring to is an increase in the funding that's made under the COVID NPA.

Senator RUSTON: Yes.

Ms Essex: The parameters for that funding are set out in the national partnership agreement. That would be expenditure that the states and territories had reported to the administrator; that they had reported to the National Health Funding Body. Ms Cahill has joined us—she will have even more detail than I do. But the states and territories will have reported expenditure that is eligible under the partnership. That will have been assessed, and that will then flow to a payment under the partnership.

Senator RUSTON: Could you maybe explain to me why, of the $886 million, a straight-out increase in payment to Victoria of exactly $600 million was made, and yet in exactly the same period there was $94 million less allocated to New South Wales?

Prof. Murphy: Ms Cahill can explain the way this works.

Ms Cahill: Senator, the way the payments work under the National Partnership Agreement on COVID-19 Response is that the states and territories provide their estimates to the administrator and then, over time, they can change those estimates. Then, of course, there's a reconciliation process. What sometimes happens with those partnership payments is that the states don't always know exactly what they're going to need to do in response to an evolving pandemic. So sometimes they will have made a larger estimate earlier and then they won't make an estimate—they won't seek further payment for some time. That's actually what happened with some of the New South Wales payments. New South Wales hadn't sought any additional payments—that's why some of those funding figures look different between the states—whereas Victoria had recently sought some additional funding and then that's been reflected in those estimates. That's very much changeable and will all get sorted out through the reconciliation process that makes sure that every jurisdiction has just been paid what they actually are entitled to. As Ms Essex was explaining, the other component that went into the update for the most recent budget was also the current government's extension of that partnership funding agreement from the end of September to the end of December. So the update in the October budget reflected both our estimates for that additional part of the year and the actuals that had changed in the period since March.

Senator RUSTON: Would it be possible to provide me with some information because, just to read it into the Hansard, South Australia had a $92 million increase in their COVID funding, Tasmania had a $26.8 million increase, New South Wales had a $94 million decrease, Queensland had a $140 million increase, Western Australia had a $99.4 million increase, the ACT had $22.6 million, the Northern Territory went back by $800,000 and Victoria went up by $600 million. I mean, has the federal government made a decision that Dan Andrews is going to have a train as well as $600 million?

Senator Gallagher: Did you listen to the answer?

Senator RUSTON: These figures are quite extraordinary.

Senator Gallagher: So, no, you didn't listen to the answer.

Senator RUSTON: I did listen to the answer.

Senator Gallagher: You're going to run that line.

Senator RUSTON: It would be really appreciated if we get some more information, because it seems an extraordinary—

Senator Gallagher: We gave you the information.

Senator RUSTON: No, you didn't give me the information. You told me that there was a mechanism. I'd like to see the advice and I'd like to see more details around how that reconciliation process has occurred, because it seems extraordinary that, on the eve of the Victorian election, there is a $600 million dollar round figure allocation to Victoria when every other state seems to have a proportional allocation.

Senator Gallagher: I can hardly see how it can have an election context.

Senator RUSTON: I'd be keen to understand from the department the process that sat behind that to make sure that—

Senator Gallagher: Are you suggesting that hospital funding decisions, where they're going through a national partnership and a reconciliation and checking process, which is the evidence that you've just heard, are

somehow influenced by the timing of elections? Is that the allegation you're putting? If it is, you should put some evidence out there to support that.

Senator RUSTON: Well, I provided the evidence and the budget papers—

Senator Gallagher: No, you haven't. You've read out some numbers and then you've made a whole range of unfounded allegations that are not right when you've just been given the evidence you've been given.

Senator RUSTON: I haven't been given any evidence.

Senator Gallagher: You have.

Senator RUSTON: I've been given a piece of advice, and I appreciate that very much, from the officials.

Senator Gallagher: So you don't believe the evidence?

Senator RUSTON: I would like you to provide me with additional advice around the reconciliation process to satisfy myself. Thank you.

Senator ROBERTS: Chair, I'd like to table some data. My questions are for the Chief Medical Officer. Birth rates have taken a turn for the worse, starting in July 2021, as provided by the Australian Bureau of Statistics. In December 2021, the last month we have data for, births were only 6,659 against an expected 21,070. That's an almost 70 per cent reduction in live births. This has never happened in the postwar period. It is happening now. Why?

Prof. Kelly: I don't think I have an explanation for that, Senator, but I would say—

Senator ROBERTS: You're the Chief Medical Officer.

Prof. Kelly: If I could just continue. In my answer to previous questions from other senators, I think it's somewhat disingenuous to take one month—

Senator ROBERTS: I'm taking the last six months, and especially the second-last month and the last month of 2021. It's already clear this is not an accident. This is not a chance event. This is a dramatic decrease in births.

Prof. Kelly: I'll have to take that on notice, Senator.

Senator ROBERTS: I hope you will. I've provided the data for you.

Senator Gallagher: Senator, we're just making some checks on that document to check it for tabling. The secretariat is just working on that.

Senator ROBERTS: This is a six-month downward trend in live births—months of below-average births. It's not one outlier month. How mad does it have to get before you show any interest?

Prof. Kelly: I'm not quite sure what responsibility I would have in relation to birth, Senator. I won't go into the reason why we have births, but I'm not sure that I'd have any influence on people's choice about pregnancy.

Senator ROBERTS: That's exactly the point. There's no choice. These people are not conceiving. They're having miscarriages at an increased rate and they're not giving birth to anywhere near as many as in the past. Births have fallen 70 per cent.

Senator Gallagher: Senator Roberts, we've got the document that you sought to table. I think it'd probably be fair to allow people some time to just cross-check that. I think you cited that it's from the ABS website. The point you raise, if it holds up, is an interesting one which is worthy of some further information, including just checking these numbers.

Prof. Kelly: Just quickly eyeballing it, it's fewer than 1,000 less than 2017. These figures do jump up and down. We do know that the pandemic has caused all sorts of issues in terms of health. I'm not sure that this is one of them, but thank you for pointing it out and I'm very happy to come back with something.

Senator ROBERTS: This is coincident with the injections, not with COVID. It didn't happen in 2020. You're not telling the complete picture.

Senator Gallagher: Well, pregnancy—I mean, if this is birth data—

Senator ROBERTS: Correct.

Senator Gallagher: it does take nine months to have a baby.

Senator ROBERTS: Correct. Now we've seen, nine months after the injections were introduced, a plummeting to 7,000 or fewer than 7,000 births when we normally have around 24,000.

Senator Gallagher: Look, I think it is right to just give people the opportunity to have a look at this data—

Senator ROBERTS: I'm happy to do that.

Senator Gallagher: without speculating.

Senator ROBERTS: Thank you, Minister. That's wonderful. The other thing following on from that is that this is a worldwide trend. Scotland has announced an inquiry into a 123 per cent increase in newborn deaths. Yet Scotland will not investigate the vaccination status of the mothers because 'it could be used to harm vaccine confidence at this critical time'. It sounds to me like we are doing the same thing here in your government, Minister.

Dr de Toca: Senator, there is data based on actual cases that shows vaccinated mothers have a lower risk of preterm birth and stillbirth than unvaccinated mothers in the context of COVID outbreaks. We can provide that information on notice. It's important to note that, as we all know, correlation and causation are two very different things. There are many things that impact birth rates, including different migration flows that we have seen in the COVID epidemic. As the secretary, the CMO and the minister said, we'll analyse that data, but we will also provide you with numerous studies that show the importance of protecting expectant mothers and pregnant women with the vaccines to reduce impacts on their unborn foetus.

Senator ROBERTS: As I recall it, Britain has now stopped injecting pregnant mothers. As I recall it, Denmark is now saying they don't want to inject anyone under 50. As I recall it, Pfizer did not do testing on pregnant women. Also, are you aware—

Prof. Kelly: I'd actually correct that record. You've jumped three steps there. I think Dr de Toca has very clearly stated that it has a protective effect for pregnant women. I'd also—

Senator ROBERTS: I disagree.

Prof. Kelly: I would like to put on record for the committee the actual data from 2021 from the ABS. This would be provisional data, I would suggest, taken at a certain date. There's no sign of when you took that data. But here is the data as of 25 October 2022 from the ABS: Australia registered 309,996 births in 2021—an increase of more than 15,600 on registered births in 2020, lifting the total fertility rate to 1.7 babies per woman following a record low in 2020. It goes against your information.

Senator ROBERTS: We took it around the same time, Professor Kelly. What is the number of births for December 2021?

Prof. Kelly: I will look at that, but I'm sure that what you've tabled, Senator, is provisional data probably at the end of 2021 or early 2022. This is the updated data as of the last month: 309,996, which would actually make 2021 the highest birth year right back before 2012.

Senator ROBERTS: And that makes sense because of the lockdowns for the first part of 2021. What about—

Senator Gallagher: That's for 2021.

Senator ROBERTS: the second half of 2021 and particularly the last two months?

Senator Gallagher: It's for the year.

Senator ROBERTS: I understand that.

Senator Gallagher: The data is for the year.

Senator ROBERTS: I understand that. I think you need to check the first half and also the last half, especially the last two months. What are the figures for December 2021, Professor Kelly?

Prof. Kelly: I'll look at that, Senator, as I said, and I'll provide that on notice.

Dr de Toca: Senator, I would like to correct the record. While Denmark has reduced the use of additional boosters of vaccine in under-50s, they still recommend the vaccine in people under 50 that are at higher risk of severe disease, which includes pregnant women.

Senator ROBERTS: Which then raises issues about risk of the injections versus risk of COVID—

Dr de Toca: Which our authorities and the Danish authorities absolutely weigh in the case of pregnant women.

Senator ROBERTS: I'll come to some places in a minute that can contradict what you're saying. Norway has just listed heavy menstrual bleeding as a Pfizer side effect, which makes sense. Our database has 2,000 reports of the same condition from Pfizer. How does Norway's announcement not tell you where to start looking for that 70 per cent reduction in births?

Senator Gallagher: I don't think we're accepting the 70 per cent reduction in births, for a start. We've taken your table on notice. We've given you an answer from the data that's available on the ABS website. If there's anything further to add, we will come back.

Senator ROBERTS: Thank you, Minister. Let's turn to deaths. According to the ABS—you'll see the graph on the back of that page—provisional mortality has been above the long-term average for the last 12 months and, for the last 10 of those, above anything Australia has ever seen. Why?

Prof. Kelly: Well, we talked about excess deaths earlier, Senator. The reality is that, in 2020 and 2021, Australia was one of the few places in the world that had the opposite of excess deaths: fewer deaths than expected. But in 2022 we have seen over 10 million cases of COVID and, even though the case fatality rate has been low in comparison to previous versions of the virus, we have seen deaths from COVID, sadly. There's also, as we've discussed earlier today, been an increase in several different other types of diseases that have led to death—dementia, diabetes and so forth have been mentioned. So this is the experience that other countries have been seeing for the full pandemic. We've just seen it for this year.

Senator ROBERTS: I'm glad you raised COVID, because actuarial data to June 2022 shows the increase is only partly COVID, with the reduction in other respiratory diseases largely offsetting the increase in COVID deaths. The real source of these excess deaths are heart disease, such as myocarditis, and neurological conditions, such as blood clots in the brain. What's up with all the deaths from heart disease and blood clots?

Prof. Kelly: Well, as I said, there's a range of things that have increased in terms of causes of death. I don't know if Dr Gould is still here, but he can perhaps talk to some of those things. He's been doing excellent work, as he mentioned earlier, with the ABS and delving into some of these matters, which are complex but important to understand.

Dr Gould: In terms of the excess death data you're talking about, it is correct to say that there have been some causes of death which have experienced increases to higher than normal levels during 2021. They include dementia and diabetes in particular. There's not strong evidence that I have in front of me, but I can check this for you, for the cardiovascular conditions that you're talking about.

Senator ROBERTS: Thank you. The following data is from the Australian Bureau of Statistics, published in part as a result of a document discovery that I initiated a few weeks ago. In 2019, the year before COVID, the seasonal flu cost 4,126 lives. The next year, in 2020, Australia recorded 882 deaths from COVID and 2,287 deaths from the flu, for a total of 3,169 deaths—almost 1,000 fewer than the flu alone killed the previous year. Then, in 2021, 1,137 deaths were recorded from COVID and 2,073 were recorded from the flu, for a total of 3,210. This means deaths from the flu, including COVID, across the first two years of the virus in Australia were right on the long-term average of 3,255. There was nothing unusual about the Australian death rate in 2020 or 2021. Yet the COVID substances, the injections, were given emergency approval. The only unusual thing about our death rate in 2021 was that it was at a seven-year low. This makes a joke of provisional approval granted for injections out of urgency. I'd like to know how this can possibly be justified.

Prof. Murphy: Mr Kelly can answer that very eloquently.

Prof. Kelly: The effectiveness of our public health and social measures against COVID during 2020 and 2021, for the most part—including, in particular, our border closures during that period—actually stopped flu entering the country and circulating in its usual way. You've quoted 2019. That was a particularly bad year for flu. There were over 300,000 cases in that year and, as I think you mentioned, 949 deaths from flu. In 2020 there were 21,000 cases of flu. Most of those were in the first three months of the year. We had no flu season during the winter and only 37 deaths. In 2021, there were 592 cases of influenza and zero deaths. Then it rebounded this year, as you no doubt know. The issue that you've raised is an important one, though, because actually, overall, the same people that are at risk of severe flu are also those that are at risk of severe COVID. So, in a sense, one has replaced the other—you're quite right. But there is no doubt that COVID, in the absence of vaccination and the absence of treatment, which is where we were back in 2020 and for parts of 2021, is far more severe. That's why we've taken the steps we've taken. I've already quoted earlier today the extraordinarily lower rate of death for those that are vaccinated compared with those that are not.

CHAIR: Thank you, Senator Roberts. Senator Pocock—

Senator ROBERTS: You have not explained why we have low flu and COVID and yet high incidence—

CHAIR: Senator Roberts, I've moved the call to Senator Pocock.

Senator DAVID POCOCK: Thank you, Chair. Can I just start in budget paper 4. On page 136, there's a table that shows $12.38 million associated with the Australian National Preventive Health Agency special account. I understand this agency has been dormant since the early Abbott years, so I'm interested in what the money's doing in there.

Prof. Murphy: It has been, Senator, but it hasn't—to fully dissolve the agency would have required the passage of legislation, and that legislation hasn't happened. So it still exists as a legislated entity and it does have to have its notional cash assets reported every year. Mr McCormack can give you the full information.

Mr McCormack: You've pretty well covered it, Secretary. It's an entity that exists in legislation but isn't active. The PGPA Act and associated regulations require us to report on it. We compile a set of financial statements for it every year and publish it in our annual report. The only transaction in those financial statements every year is the value of the audit work that the ANAO does to verify it. There is a cash reserve, but that cash reserve is associated with the special account that the ANPHA had when it was active. It is not accessible in any way, shape or form by any other agency. Should parliament consider legislation and pass legislation to dissolve it, that nominal cash amount would fall back into consolidated revenue. Until that happens, we will—we are actually considering stopping reporting on it now that it's been more than 10 years since it's been in effect and we have that option. But hitherto we've been reporting it.

Senator DAVID POCOCK: Did you say that the ANAO still does reports on it?

Mr McCormack: The ANAO is the auditor.

Senator DAVID POCOCK: On something that hasn't done anything for a decade?

Mr McCormack: They don't do performance reports on it.

Senator DAVID POCOCK: Let's hope not.

Mr McCormack: The ANAO is the auditor of our financial statements. They audit all the material agencies' financial statements. They do the ANPHA. They wouldn't normally do the ANPHA, but they just do it because we deal with it. The value is very nominal and our chief financial officer was very excited in the 2021 financial year to have ANPHA be the first set of statements that were fully finalised in the Commonwealth simply because there was only one transaction. It's an anomaly.

Senator DAVID POCOCK: Well, if there are no plans for it, we can get rid of it at some stage. Can I just come back to the National Preventative Health Strategy. You took on notice how much of that—the percentage of that is COVID related. You said that COVID is part of that. Could you outline exactly which COVID programs are part of that National Preventative Health Strategy or counted as part of it?

Ms Rishniw: I'll ask my colleague Ms Street to detail. I think the question that we took on notice was how much of the broad government budget is spent on prevention. We talked about various things that go into that. The AIHW reports on public health expenditure and prevention in particular, the last report in 2021 from the AIHW, all governments spent about 2.4 per cent on public health and prevention in the 2019-20 year. So there's always a little bit of lag in terms of collection. But Ms Street might go into detail in terms of kind of how that's calculated.

Ms Street: So, as mentioned, AIHW, the Australian Institute of Health and Welfare, does the estimates. What they include in that—things that are specifically on preventive health, immunisation and health protection get captured in that collection. When we do—and the reporting that we've talked about, in terms of there being 2.4 across states and territories and ourselves, the 2.4 per cent was 2019-2020. When we look at the numbers now, it's much higher because of the vaccination elements. But what we do include in those figures are things like screening behaviour, drug and alcohol, chronic disease, and public health. So there's a number of things in there, but immunisation is one, which is the reason why we would see the figures for the last couple of financial years being significantly higher. But that will come out in the future reports.

Senator DAVID POCOCK: Minister Gallagher, I know this isn't your area, but I'm interested in—just thinking this through, if you said to most Australians, 'preventative health', they would want money spent on that. We can all see the benefit of that. My concern is that, if a big chunk of that is just COVID related—Minister, should that count towards a goal to have preventative health that's hopefully leading to much better outcomes and a whole range of those other things that you mentioned?

Senator Gallagher: At a broad level, I 100 per cent support more investment in preventative health care. That was the work that Professor Kelly and I did 10 years ago, perhaps, in the ACT, where we tried to shift effort. But, with the amount of resources available and the calls on it, you know, it is hard. I'm genuinely telling you it is hard to make—well, you can do it over time. It requires a fair bit of time to shift focus. That's partly because the acute system and the primary care system require so much investment. But I think you'll—I certainly think Minister Butler would have strong support around the room around looking at ways to increase focus in this area.

Prof. Murphy: To get to your point, Senator, investment in vaccination is generally accepted as a good preventive health measure. I think the anomaly that you're referring to is that we've had a huge, big demand of

COVID vaccination, which is distorting the report. But I don't think you would disagree that investment in a normal polio and vaccination—they're very strong preventative health measures, so that's why they're counted. But we agree that it is an anomalous—

Senator DAVID POCOCK: And it's potentially distorting how much we think we're spending on preventative health, but we're also potentially in the situation where, if hopefully COVID isn't—if there's a massive drop-off and then we're going to have to scramble to find that five per cent by 2030. It's a tough situation.

Prof. Kelly: If I may, I'll just say that the funding in the October budget for the Australian CDC consultation that's kicked off—

Senator DAVID POCOCK: That was my next question. Thank you.

Prof. Kelly: I'm getting ahead of you. The discussion paper was released this week, first to our state and territory colleagues, the health ministers and so on, who are very key partners in this, of course, but more widely yesterday and then today publicly on the website. I don't have a copy here, but I'm happy to make sure that's provided to the committee. But that has very specifically, as a platform of the incoming government, included many of the things that were in that previous agency that you mentioned and preventative health more broadly. So it's not just about infectious diseases; it's also prevention and prevention of chronic disease as well.

Senator DAVID POCOCK: Thank you. On the CDC, is there—what's the time line like to establish—

Prof. Kelly: As I said, the consultation—the discussion paper's there. We've done a lot of thinking and looking at what's here now and what we can learn from our experience over the last few years—in particular, in relation to pandemic prevention and preparedness and control. So that's happened. We've had good work and collaboration from international centres for disease control, specifically in the US, but also in Europe and other places. That's been brought together into this discussion document with some key questions about where we should go to next. We've been tasked with a short time line to get that back to Mr Butler for consideration, with a view to having further announcements at the next budget.

Senator DAVID POCOCK: So not before June next year?

Prof. Kelly: That'll be in May for the budget and then subsequent to that—

Senator Gallagher: We've started work on that.

Prof. Kelly: There's no rest.

Senator DAVID POCOCK: So the second half of next year at the earliest?

Prof. Kelly: At the earliest, yes. But this is potentially a very big change, so getting that right is really important. Certainly, feedback from the many stakeholders is that they are very excited about this. We've talked about it for my entire medical career—certainly since 1987. That was when the first calls for an Australian CDC were made. So, yes, it might seem like a long time, but I think in terms of these types of reforms, it will actually go quite fast. It may well be, depending on where the discussion and the consultation goes to, a need for legislation, for example, to form this entity. I'm almost certain it will. So that will obviously take time to fit it into the agenda and it will require support in the Senate. I'm happy to talk through that when it comes to that point.

Senator DAVID POCOCK: Thank you. In terms of the role, do you envisage it'll extend to looking at growing the public health workforce and looking at where the gaps might be?

Prof. Kelly: Workforce is absolutely a part of that process. My colleagues might want to talk to some of the work that's been done there, specifically in public health workforce.

Senator DAVID POCOCK: The other thing was whether it would have any responsibility for delivering the National Preventive Health Strategy.

Prof. Kelly: That's on the table, but no decisions have been made. It'll obviously be a decision of government about how that works and what goes into the CDC as a key component of the scope element. There are specific questions in that discussion paper I mentioned around those types of things. But certainly workforce, chronic disease prevention, health protection and all of these things are within scope at the moment, and then how that works through. Particularly with that, we don't want to miss the chance to stop gaps, but we also don't want to create overlap, particularly with the states and territories. So all of those things are on the table now.

Ms Rishniw: Senator, I would just add that, in terms of the National Preventive Health Strategy, obviously all states and territories and the Commonwealth have a role in that. The CDC may have a specific role, but all governments will have a role in delivering on the actions and targets in that strategy. So in many ways that responsibility will be shared. One of the kind of key elements of the National Preventive Health Strategy is

looking at what is that public health workforce. Obviously, we've learned through COVID and the strategy actually goes to that as well.

Senator DAVID POCOCK: Thank you.

Senator STEELE-JOHN: The settings that we are currently on in each state and territory rely on people taking personal responsibility and following advice to wear a mask. What program is the federal government currently running to educate the community in relation to wearing masks?

Prof. Kelly: I think I'll take that one, Senator. It's related to the discussion I had earlier around the community protection framework. So at different points in the pandemic over the coming months—and there is a wave now; there will be other waves in the future—that advice will change. We have a plan in relation to communications to switch on more intense messaging around mask wearing when a wave is on. We mentioned earlier the Queensland announcement today about an amber—what they call amber in their framework is very similar in that community protection framework. So we are increasing messaging around masks now.

Senator STEELE-JOHN: Right. Just to clarify, there is a public communications campaign going on right now about mask wearing funded by the federal government?

Prof. Murphy: There's an ongoing communications campaign. I don't know whether Ms Balmanno will come up and have a talk. We certainly have ongoing social media campaigns on those protection mechanisms. But Ms Balmanno can talk to you.

Ms Balmanno: We have four strands of creative in market at the moment. One of those is about COVID safe behaviours, which includes mask wearing. The dominant messaging at the moment is around the oral antivirals and for people who are eligible to make sure they're having those early conversations with their doctor so that, if they catch COVID, they can get onto the antivirals quickly. But, obviously, as the epidemiology changes, we change the balance in terms of the advertising.

Senator STEELE-JOHN: So, at the moment, of those four pieces of creative, I wonder, just for time, if you can take on notice who is providing us with the information about those creatives and pieces of content spend, particularly in relation to audience that you're targeting. So it's the pieces of creative themselves, if you're able to provide them.

Ms Balmanno: We can definitely do that, but all of our creative is also always available on our website. We can provide all the links to those.

Senator STEELE-JOHN: Yes, thank you—also the information that informed those pieces of creative and where you are targeting them in terms of the audiences that you're selecting now. Are we encouraging the use of—sorry, does the creative encourage the use of high-performance masks, P2 and N95? Does it specify that?

Ms Balmanno: As you'd appreciate, the nature of an ad doesn't go to that level of detail. These are either radio advertisements or digital advertisements or, in this case, some of it is the posters that you see at bus stops and shopping centres and those sorts of things. It doesn't go to the detail of the mask type. But obviously the department does publish information about different masks and, particularly, the performance of different masks is something that the Therapeutic Goods Administration has assessed and published information on.

Senator STEELE-JOHN: With respect, given that it's creative that you have created, you could have decided to make it specific to high-performance masks. I've seen some of these ads and they say, 'Wear a mask'. There was a creative decision made there somewhere to say, 'Wear a mask' rather than 'Wear a mask, particularly of these types'.

Ms Balmanno: You're absolutely right. The issue, though, is that the advertising in this sense is not just about masks. It has a range of messages that we're trying to encourage people, including, for example, stay home when you're sick. That's obviously one of the great preventive behaviours people can take to avoid spreading COVID-19 and other illnesses. So it has a range of different messages. Within that context, going into the detail on the masks would have made it too complex. But you're quite right—it is a decision.

Prof. Murphy: And particularly, Senator, if one were proposing broad community use of high-performance masks, it would be irresponsible to do that without current messaging that they are not effective unless they're properly fitted and applied. I think the general messaging is that any mask is better than no mask, certainly in terms of people spreading coronavirus. The high-performance masks are much better to protect the individual from getting it, but they do need to be—if they're not fitted properly, they're probably worse.

Senator STEELE-JOHN: I'm aware of that. Just in terms of time—thank you. I do know that.

Ms Balmanno: We do have information that supports the proper fitting and selection of masks.

Senator STEELE-JOHN: I also know that. Thank you. Could I just go to the question then of modelling for the upcoming wave. There have been several announcements made about this, in this week particularly, framing this up as the beginning of the wave. Has the federal government done modelling of what the next wave of COVID-19 infections may look like?

Prof. Kelly: The federal government has not done that modelling for the general community, but several states have. They're all fairly—at a high level have been made available to us. But, realistically, Senator Steele-John, several months ago I predicted there would be a wave in November. I don't need modelling to do that. We've got real data and we've got real surveillance data now in real time. So the usefulness of modelling in these matters is becoming, in my view, less important. But the real data that we have and understanding the vaccination rate, et cetera, is important, as well as looking at recent international experiences—for example, in Singapore in the last couple of months. I think that's what we will see. We will see a short, sharp wave. We'll see quite a lot of cases. I don't think there will be a major increase in hospitalisations at this point, but we are dealing with quite a large number of different and new variants, so it is a little bit more difficult to predict.

Senator STEELE-JOHN: Okay. Which states and territories have undertaken to model the current wave?

Prof. Kelly: I certainly know New South Wales, Victoria, South Australia and, I believe, Queensland—possibly WA, but I'm not sure.

Senator STEELE-JOHN: So most of them.

Prof. Kelly: Pretty much all of them, yes.

Senator STEELE-JOHN: But the federal government hasn't?

Prof. Kelly: Not at this time, no.

Senator STEELE-JOHN: Okay. That is of concern.

Prof. Kelly: As I said, Senator, we don't need—

Senator STEELE-JOHN: Well, the states and territories decided they did.

Prof. Kelly: You do modelling for two reasons—first, at a time of uncertainty, and we're in less uncertainty now; and, secondly, when modelling can demonstrate what you need to do to decrease a wave. We know how to decrease a wave. So it's less important than it was earlier in the pandemic environment.

Senator STEELE-JOHN: The majority of states and territories obviously disagree with you, but I will move on because we are pressed for time and I must go to long COVID. Can you confirm the amount of funding that was allocated in your recent budget specifically for long COVID research supports or treatments?

Prof. Kelly: I'm not aware of any funding specifically for long COVID, Senator. But we've had quite a lot of discussion around the NPAs with states, for example. The others will be able to talk to that.

Senator STEELE-JOHN: So no funding specifically for long COVID in the budget?

Prof. Kelly: No. The reason for that is, as mentioned earlier, that there is a parliamentary inquiry in the House that is looking to that. I think other countries, I'm sure you know, have made—

Senator STEELE-JOHN: I absolutely do know.

Prof. Kelly: But we, as part of our preparation for our submission to that inquiry, have had extensive conversations with particularly the US, the UK, New Zealand and Canada in relation to long COVID—and several other countries in Europe, actually. It's guesswork about what's needed in those countries. As I mentioned earlier, long COVID is definitely a thing. I am absolutely convinced that there is long COVID. We do need to do something about it, but it needs to be based on information and data, which we're working on at the moment.

Prof. Murphy: Senator, I think it's important to note that, under all the agreements—the National Health Reform Agreement NPAs with the states—we do fund the Commonwealth share of all of those clinics the states and territories fund. Some of them have set up dedicated clinics and we fund our share. Obviously, there is a significant MBS expenditure that obviously is demand driven, including chronic disease management items which can be used to get allied health treatment. So there is funding, and there's been a lot of previous funding through the MRFF, for long COVID research. So I think there has been funding, but I think you're getting at treatment funding.

Senator STEELE-JOHN: Well, no, my question specifically asked in relation to specific funding for long COVID research, support and treatments. Professor Kelly, you just referred to the work being done overseas as guesswork. Surely funding research specific to long COVID would in fact reduce the guesswork.

Prof. Kelly: Absolutely. There is $8.1 million that has been allocated specifically to long COVID research from the MRFF. There are others that have come from the NHMRC. There might be others in the room who can

talk more specifically to those research figures. But, just apart from that, there's been a very large amount of work done in the last couple of months within my own area and other areas of the department trying to get a sense of what is actually happening in Australia. I'm on record as saying this previously: we do need to be cautious about extrapolating exactly from what's happened overseas because of our different experience here.

Senator STEELE-JOHN: Professor Kelly, I would usually let you go for bit longer, but just for time and to clarify, the funding you just referred to through the NHMRC—

Prof. Kelly: The MRFF.

Senator STEELE-JOHN: The MRFF—is that for COVID research or specifically long COVID research?

Prof. Kelly: Specifically for long COVID there has been $130 million that has been given to COVID research, vaccines, treatments and other elements.

Prof. Murphy: There are some basic research projects in long COVID, particularly $3 million to the Institute of Health and Welfare to get that important data that Professor Kelly was talking about that we haven't got.

Senator STEELE-JOHN: Was that identified in the budget or was that—

Prof. Murphy: It was previously allocated. The MRFF is an ongoing measure. Dr Somi can give you the details if you like.

Dr Somi: So, just to confirm, there have been investments. I don't have the details of the project specifically. I do confirm it has been 8.1 million specifically for research to understand long COVID and the impacts on populations, particularly vulnerable populations.

Senator STEELE-JOHN: Can you take that on notice and provide it to us?

Dr Somi: Yes.

Senator STEELE-JOHN: Thank you.

Senator RUSTON: In the March budget, there was $6.8 billion for medical research that was made up of 3.7 from the National Health and Medical Research Council, 2.6 from the MRFF and 500 million from the Biomedical Translation Fund. Can you tell me where I'd find that in the budget papers?

Dr Somi: Are you talking about the October budget papers?

Senator RUSTON: Yes—I'm just trying to understand whether that's still there.

Dr Somi: Definitely the funding is still available. I would have to look exactly where the figures are in the budget papers. But those funds are still remaining in the budget.

Senator RUSTON: I'm happy for you to take it on notice.

Senator Gallagher: Technically, if there's something in the March budget that continues, it doesn't get repeated in the October budget.

Senator RUSTON: That's fine. I'm just making sure. If you can just provide me with whatever evidence there is to that, that's fine. There was no criticism.

Senator Gallagher: That is the evidence—it appeared in the March budget and it hasn't been reversed.

Senator RUSTON: It hasn't been reversed. Thank you. In Budget Paper No. 3 on page 30, there's a table about health infrastructure projects. Under the South Australian column, there's an amount for $4.3 million. Under the notes it says that this is providing funding to support the implementation of the Regional Cancer Treatment Centres for Radiation Therapy Program in Victoria and South Australia. Could you confirm that $4.3 million for South Australia is for the regional cancer centre in Mount Gambier Limestone Coast?

Ms Essex: My apologies, Senator, I'm just having trouble finding the relevant brief. I'll need to take it on notice, but we should be able to get back to you fairly quickly.

Senator RUSTON: In response, I just need to understand where the grant process is in relation to that—assuming, of course, that is the one—and just where the agreement's been reached with the South Australian government in relation to co-funding. If I could just get some information back on that, that would be great.

Ms Essex: We'll get that for you on notice, Senator.

Senator RUSTON: Thank you very much. Can I just go to a few questions on women's health. During the election, Labor matched the coalition's commitment to fund 20 new Gidget Foundation perinatal mental health and wellbeing services. In the budget it appears that there's been a provision for 12 and not 20. Can you confirm that?

Ms Rishniw: The commitment still stands for 20 Gidget Foundation centres. The funding allocation is for 12, with a trial at the end of it to inform the ongoing development of the additional eight. It also takes into account MBS costs to be able to fully support perinatal mental health. Mr Roddam may want to add to that.

Senator RUSTON: Just before you go to that, can you just explain to me where the additional eight exist in terms of commitment? There's meant to be an election commitment to 20 perinatal, but is it contained anywhere in the papers? Has it been provisioned for? In the papers it says only 12. So I'm just wondering whether—is it just that we need to believe you that there's another eight or is there something that you can point to for me?

Mr Roddam: There are 12 provisioned in the budget, which comes to the original funding amount of the election commitment, because the election commitment or that envelope of funding didn't include MBS costs. The way the Gidget Foundation's model works is that it provides facilities to support clinicians to support people with perinatal mental health needs, and they then charge Medicare. That then includes the Medicare costs. So there are the initial 12, as Ms Rishniw says, then an evaluation will inform the rollout of the following eight.

Senator Gallagher: The government's committed to the full election commitment. And the Gidget Foundation is aware of this.

Senator RUSTON: Yes, I'm aware they're aware of it. I was just trying to find—pointing to the budget paper somewhere where the additional $8 million was, because you're saying that the decision to move from 20 to 12 was on the back of the increase in the Medicare MBS items that were going towards it. Yet I think on Tuesday night, when we were talking about urgent care clinics, you said that there was no provision in relation to MBS and the additional costs of additional MBS items.

Senator Gallagher: We're finalising the model for the urgent care clinics, whereas this is costed—we know how much it costs. We've made the commitment. We'll evaluate after the 12, and the Gidget Foundation is aware of this. So it's full steam ahead.

Senator RUSTON: So can I take from what you just said, Minister, that, in your design and evaluation of the urgent care clinics, if it comes out that they are actually going to cost more per clinic than the $235 million, you won't be rolling out 50 clinics?

Senator Gallagher: We committed to the 50 clinics. We went through this the other night.

Senator RUSTON: No, I'm just saying that, if you are going to compare apples to apples, there's no provision at all for the extra eight. You're saying you're committed to them. So I'm just interested that there is no provision for it.

Senator Gallagher: Yes, but we'll do it carefully, we'll evaluate and we'll make provision and we'll do the costing—

Senator RUSTON: And then you'll cut them if that's the decision that you want to do. I don't think anyone can have the confidence that you won't.

Senator Gallagher: No-one's talking about cutting them, but evaluation is going to be an important part of the way we budget as well, to make sure that the money that's being invested is working and delivering the outcome. That's part of the responsible budgeting approach that we're taking, which differs from the previous administration.

Senator RUSTON: Well, if you're taking a responsible approach, I don't know why you haven't budgeted for the full 20 if you're actually committed to doing them. But moving on to—

Senator Gallagher: Because we're evaluating.

Senator RUSTON: Yes, you're evaluating. You're evaluating the urgent care clinics, but you haven't taken into account the Medicare component of that. You're contradicting yourself.

Senator Gallagher: We're finalising the—no, we're not. We went through this the other night.

Senator RUSTON: I know we did.

Senator Gallagher: We were very clear on it. We committed to the 50—

Senator RUSTON: We were, but you're not being very clear here.

Senator Gallagher: We are committed to funding them, and we will evaluate, but we'll also need to consider the model.

Senator RUSTON: I'll move on to endometriosis. Can I acknowledge Assistant Minister Kearney, who very graciously yesterday acknowledged the commitment of the previous government in relation to the $58 million that was made available in the budget in March to support women with endometriosis. It was a very gracious gesture on her part—one that we don't often see. So I commend her. The two announcements yesterday were in

relation to the pelvic pain GP clinics for $16 million and the MBS MRI rebate for $25 million, which adds up to just over $41 million. I'm just wondering: the remaining items that were contained in that $58 million promise in March, where are they and is the government still committed to the delivery of those other items?

Ms Rishniw: Ms Schofield can give you the detail, but once again the commitment to the 58.3 is maintained. The announcement yesterday specifically went to the announcement of the expressions of interest around endometriosis and pelvic pain clinics and those elements specifically, but the overall package remains.

Senator RUSTON: And the commitment to the individual items in that package remains—and whereabouts is that contained in the budget?

Ms Rishniw: They were part of—as the minister outlined, nothing has changed.

Senator RUSTON: Great. Thank you very much. In relation to the IVF deferred funding, in relation to women or parents with cancer or genetic conditions to have their eggs or embryos and sperm frozen, that appears to have been deferred in the budget. Is that correct?

Ms Rishniw: I'll go to my colleague Ms Shakespeare on that one.

Ms Shakespeare: Yes, Senator, to allow more time to work with the sector on how that measure is rolled out. It's a commitment to implement it, but the form that it takes—to ensure that it doesn't have a negative impact on people who currently have their embryos and other things stored, we just need some more time to work with patient groups and with the sector.

Senator RUSTON: Finally—you may need to take this on notice, because I'm getting eyeballed—in relation to Oncotype DX cancer testing, could you please provide me some advice in relation to the MSAT process that has gone around that—why we still do not have access to it and why you are spending clearly hundreds of thousands of dollars defending releasing documents under FOI in relation to that particular case. Can you come back on notice. Thank you.

Senator ROBERTS: My question is to the Chief Medical Officer. The previous Prime Minister repeatedly said that Australia has no vaccine mandate. I'd like you to clarify something you said or alluded to earlier today—that the states drove it. The Morrison-Joyce federal government bought hundreds of millions of doses of the injections. The federal government indemnified the states. The federal health department provided the data and systems access needed for the states to enforce their mandates. State premiers said that their vaccine mandates are in line with the unconstitutional so-called National Cabinet. The federal government mandated vaccines in several departments. The federal government funded state restrictions that empowered the prime minister. In other words, the prime minister of the previous government enabled and drove the vaccine mandate. What I want to know is what was your role in that breach of basic health principles—informed consent replaced with coercion and the doctor patient relationship being invaded. Why were those vaccine mandates put in place when the federal health minister at the time, Greg Hunt, said the world is engaged in the largest clinical vaccination trial? How can they force a trial of an experimental drug?

Prof. Kelly: I'm just not quite clear what the question is there, Senator.

Senator ROBERTS: What was your role in that? There was a lot in there, so maybe take it on notice.

Senator Gallagher: It's probably been dealt with before in a couple—

Senator ROBERTS: No, it hasn't.

Senator Gallagher: Really? That kind of—

Senator ROBERTS: I'd like you to clarify your role in driving or enabling the Prime Minister to drive those vaccine mandates around this country.

Prof. Kelly: My role has been fairly clear and has been voiced in multiple Senate hearings over the last several years and before me Professor Murphy—

Senator ROBERTS: In relation to the vaccine mandate.

Senator Gallagher: Well, AHPPC advised the National Cabinet.

Senator ROBERTS: Take it on notice.

Prof. Kelly: I chair the AHPPC. There's nothing to take on notice. I'm the chair of the AHPPC. The AHPPC has advised National Cabinet. National Cabinet has made decisions in relation to vaccination. That's it.

Senator ROBERTS: Thank you.

Senator RUSTON: Earlier in the day, in a line of questioning in relation to APS code of conduct breaches, the agency sought to bring me back information. I was just wondering whether that information has been brought. If so, can you bring it back after dinner?

CHAIR: Thank you. We're going to the dinner break now, for 45 minutes. We will return at—

Senator Gallagher: Still doing outcome 1?

CHAIR: No, we'll provide advice to you very shortly. The committee is about to hold a private meeting, and then we'll be providing advice very soon after that.

Senator Gallagher: So do you want us to hang around or not?

CHAIR: Oh, sorry. Outcome 1 we're finished with.

Senator RUSTON: We're going to aged care after the dinner break.

Senator Gallagher: Right. So outcome 1 people can go.

CHAIR: Outcome 1 we are agreeing to release. We are holding a private meeting. We will advise you shortly.

Senator Gallagher: More information later—okay.

Prof. Murphy: Chair, can I just ask: the PSR director from the MBS is the only external official who's been hanging around waiting.

CHAIR: That's in outcome 2.

Prof. Murphy: That's in outcome 2?

CHAIR: They can go.

Prof. Murphy: So any other officials from outcome 2?

CHAIR: The committee needs to hold a private meeting to look at the order of business. We will provide advice to you.

Prof. Murphy: But the PSR director can go?

CHAIR: We will provide advice in five minutes. Thank you.

Proceedings suspended from 18:33 to 19:21

CHAIR: The committee will resume. We will move to outcome 3, Ageing and aged care. I welcome back Senator Gallagher, representing the Minister for Health and Aged Care, the Hon. Mark Butler MP. Minister, do you wish to make an opening statement?

Senator Gallagher: No, thank you.

CHAIR: I welcome back Professor Murphy, Secretary of the Department of Health and Aged Care. Professor Murphy, do you have an opening statement?

Prof. Murphy: No, thank you.

CHAIR: Senator Rice, you have the call.

Senator RICE: I wanted to start with asking about where we're at with the development of the new aged-care act—what's happened since the election, what the next steps are and what the time line is.

Ms Metz: The new aged-care act falls within the responsibility of my branch. Obviously, the royal commission recommended that the act should start mid next year, which wouldn't allow a lot of time for parliamentary passage. So at this stage we're aiming to have the act ready for introduction next year. The precise timing of that will depend on—will be a decision for government. We're working on the act and various components of it. Particularly at the moment, we're focusing on the rights aspect and the initial entry criteria for people. We're working with the Office of Parliamentary Counsel. There are a lot of different components that will go into the act, so lots of different policy areas are working on aspects of it. The new Support at Home Program, the new regulatory model and all of those aspects are being worked on simultaneously.

Senator RICE: Okay, and what's been the consultation and engagement program up to date and what's planned from here?

Ms Metz: We've been engaging very closely with the council of elders and National Aged Care Advisory Council on different aspects of the act. They're really our initial point of contact. We've also got an expert advisory group that we've set up within the department with experts across areas ranging from human rights. We've got representation from consumer peaks on that organisation. Ms Laffan might have more information about that. But we've been engaging primarily with those groups at this stage.

Ms Laffan: Certainly we intend to have an exposure draft of the legislation prior to introduction, so that will largely be the consultation process.

Senator RICE: Okay, so you'd be that far down the track before you had broad consultations?

Ms Laffan: As Ms Metz mentioned, we have been consulting on policy elements of the new aged-care act.

Senator RICE: With a fairly important group of stakeholders but a fairly limited group of stakeholders so far.

Ms Laffan: Even, for example, on home care reform, which will form a large component of the new act, there's been a separate consultation process on that. So, if you break up those policy elements, each of those have had their own policy consultation processes.

Senator RICE: I suppose I'm interested in sort of overarching framework and noting the difference. I'm pleased that you said that it's focusing on what the rights based approach looks like, because certainly the royal commission very strongly said that it had to be a rights based approach and that 'Framing the reform agenda as one based on entitlement is essential' and 'It should provide an entitlement to the support and care each individual needs to prevent and delay the impairment of their capacity to live independently':

> The new Act must enshrine the rights of older people who are seeking or receiving aged care … A rights-based approach must guarantee universal access to the supports and services that an older person is assessed as needing.

Do you feel that the act that you are drafting is going to be consistent with what's stated there in the findings of the royal commission?

Ms Laffan: The precise drafting might differ from what the royal commission said. We have to work with the Office of Parliamentary Counsel around exactly how that's framed. But, in terms of having a statement of rights and that being the basis for the legislation, that's certainly the intention.

Senator RICE: So the intention is a rights based approach that would guarantee universal access to the supports and services that an older person is assessed as needing? Is that consistent with what's being drafted?

Ms Laffan: That's correct. If I just take you to the current Aged Care Act, the current Aged Care Act focuses on aged-care providers. It focuses on the funding of those providers. So the big difference will be the new aged-care act being rights focused and person focused. It'll be around how a person accesses care. It won't be divided so much into the different kinds of care models but presents a kind of a single entry way and really focuses on how a person travels through the aged-care system rather than focusing on the provider.

Senator RICE: Yes. The reason I'm focusing on this is that, reading the statements of the final findings of the royal commission, it's talking about enshrining the rights of older people, elements of a core human right, and the right of everyone to the enjoyment of the highest sustainable standard of physical and mental health. Yet, if you read the page on the website about the new act, it doesn't talk about enshrining the rights of older people at all. It places older people, older Australians, at the heart of the aged-care system. It outlines the rights of older Australians. But it doesn't talk about enshrining the rights of all Australians to receive the care that they are assessed as needing. So I was just wondering whether that was a matter of drafting or is that a specific difference between the approach that's been taken as outlined in the royal commission and what's being drafted.

Ms Laffan: It's certainly our intention. For example, we've already had some initial conversations with the groups Ms Metz mentioned on the objects of the act and how we frame rights as part of that. But we're also talking to our stakeholders about having things kind of beyond objects so that we can have rights in there that are not just aspirational but enforceable, and to be enforceable, and how we need to put those and filter those throughout the act, working on general powers and other things like that and general duty of care—so how we reflect those rights then into enforceable provisions throughout the act. So that's certainly something that we're working on.

Senator RICE: Okay. Again, the royal commission outlined that the purpose of the aged-care system must be to ensure that older people have an entitlement to high-quality aged care and support and they must receive it. So that's consistent with what you're drafting?

Ms Laffan: Yes.

Senator RICE: Good. Will you be doing any more extensive consultation beyond the key organisations that you mentioned before, before you put out an exposure draught? I certainly know, being the portfolio holder for the Greens, that the number of stakeholders in the sector is enormous, with different perspectives.

Ms Laffan: I think, Senator, it depends on the different areas of the act that we're talking about. The exposure draft will be the time where our stakeholders see everything as it hangs together and how it fits together in a consolidated view. But we will have, and we have been having, regular stakeholder consultations on various aspects of the act. For example, we're currently consulting on new aged-care quality standards. That gives a sense

and a chance for our stakeholders and those interested to input into what those standards look like before they are then lifted and put into the new aged-care act. Likewise, on the new regulatory framework, we've been consulting on that. That will then be filtered into the new aged-care act as well. Largely, to begin with, it's about those component parts that we'll be consulting on before bringing it together into the new aged-care act. And that's at the point of exposure. That will then be filtered into the new aged-care act as well. Largely to begin with it's about the component parts that we will be consulting on before bringing it together into the new aged-care act at the point of exposure.

Senator RICE: Obviously exactly when it gets introduced will be a matter for government, but if we are working on a timeline of having the act potentially being introduced in the middle of next year, what would be your timing on getting the exposure draft released?

Ms Laffan: We want to give people a significant amount of time to look at the draft. Then obviously we need a chance to make any changes as a result of that exposure.

Ms Metz: What I would say about that is that a number of the critical policy components of the act are still under development, so delivering an act for introduction to parliament in the middle of next year is unlikely to be possible. An exposure draft would be much more likely towards the middle of next year. As Ms Laffan said, we would be looking to have a significant period of time for people to comment on the legislation prior to introduction to iron out any potential issues before it is introduced to parliament.

Senator RICE: That's useful information. So in fact you're saying that we are not likely to have a new aged-care act in the middle of next year—

Ms Metz: Not commencing in the middle of next year.

Senator RICE: The end of next year rather than the middle of next year.

Mr Lye: It might be before the end of next year. It will depend a little bit. What we've found on the consultations we're doing on the home care reform component of our reforms, we've been out and got quite definite feedback from stakeholders, and we're back out talking to them again off the basis of some of that feedback, so it depends a little bit on the kind of response we're getting from people around elements of the program. I think that is true of the act as well.

Senator RICE: In terms of the consultation you're doing at the moment, returning to the overall framework and basically the underlying philosophy of the act, are there some key issues of tension that you still need to resolve in terms of how the act is going to deal with those in terms of what the stakeholders are expressing to you?

Ms Metz: There is nothing specifically I could identify. We've had good feedback from stakeholders and taken that on board.

Senator RICE: I'm wanting to know whether there are specific approaches that specific stakeholders are taking which are in tension with the approaches that other stakeholders are recommending.

Ms Metz: There's no particular tension that I could identify, but we're in ongoing discussions with stakeholders about the approach.

Senator RUSTON: Can we come back to our workforce? Have you got any further information in relation to the current projected workforce shortages in residential aged care across Australia?

Mr Lye: Over and above what we discussed on Tuesday night?

Senator RUSTON: Yes, I'm just wondering if you'd had an opportunity, because I was looking for enrolled nurses, nurse practitioners, registered nurses in aged care. We just had a vague number of 10,000 somewhere.

Mr Lye: I think the gross number, before we look at all the program effort, is that 11,800 RNs would be needed.

Senator RUSTON: Workforce shortages as we currently sit here now, before we move to the changes in care minutes and 24/7?

Ms Strapp: Yes, that number that Mr Lye just mentioned is the number before for registered nurses before taking into account pay rises and the other programs we have in place to plug those workforce shortages. That is the current gap.

Senator RUSTON: Sorry, maybe I'm confusing myself here. As we sit here today, before any changes come into effect, because they don't come in until June, the workforce shortages for registered nurses in aged care, you're saying, is 11,800.

Ms Strapp: That's the shortage, that's what we need, taking into account the 24/7 nurses and—

Senator RUSTON: No, sorry, that's not my question. My question is, right now, if we disregard all the legislative changes, what is the current workforce shortage?

Mr Lye: I'm not sure if we've got a figure, but we will check.

Ms Gleeson: Taking into account just the baseline gap, that is in the order of 2,000 for registered nurses and nurse practitioners combined.

Senator RUSTON: What is the date of that information?

Ms Gleeson: We are using the financial year 2023-24 as our reference year, so that is what our forecast gap is in that year.

Senator RUSTON: So the forecast gap in that year was forecast prior to any legislative changes?

Ms Gleeson: Yes, that's correct.

Senator RUSTON: So if there was 2,000 short, and you're saying that there is 11,800, then one can assume that the changes are likely to be generating about 9,800.

Mr Lye: The 200 care minutes commitment that was made last year I think, last calendar year, is 8,944, so that adds to your 2,000. Then the commitment to 24/7 nursing that the current government has made is 869.

Senator RUSTON: In 2023-24?

Mr Lye: That's right. Those two figures add together with the 2,000 to give you the 11,758 figure.

Ms Gleeson: RNs and nurse practitioners.

Senator RUSTON: So when you say you've baselined it to 2023-24, what was your starting point? What was your data starting point on which you built that? Because obviously you have built it to 2023-24 because that's when you are thinking these other things are going to come into play, I get that, but what was your data that you started with. Clearly you didn't start with 2023-24 data. Was it a work force survey of a particular time? What was the date of the starting point?

Ms Gleeson: The workforce data is based primarily on the aged care workforce census that we did in 2020.

Senator RUSTON: So in terms of the true baseline, it's 2020?

Ms Gleeson: That's correct. Then we apply growth figures to that to understand how the workforce grows without any policy interventions. Then over and above that we look at the policy changes that have been made in terms of care minutes and 24/7.

Senator RUSTON: So on the basis of these figures we're looking at an increase of around 1,000 nurses a year or thereabouts in subsequent years.

Ms Gleeson: With no policy changes of care minutes and 24/7?

Senator RUSTON: No, I think you've got your policy changes in here. If I'm looking at the table that I'm assuming you are looking at, which is the registered nurses and nurse practitioners supply and demand headcount in residential aged care facilities financial year 2023-24 to financial year 2031-32?

Ms Gleeson: I haven't got that full table in front of me. I've just got the forecast for the next couple of years. I'm not sure which table you're using.

Senator RUSTON: What I'm trying to understand is that you've used the 2020 workforce survey, so I'm assuming there has been some quite significant impact on aged care because of COVID. I wondered whether there has been any additional analysis on this to try and understand whether the impact of the two COVID years on the workforce in aged care and all the other subsequent challenges we've had in workforce have been factored into these numbers in any way?

Mr Lye: I think that's what Ms Gleeson is saying, that we have taken that original baseline census data and we have then extrapolated through to get to the 2023-24 year. We are obviously trying to look at that year because that's when all of our policy changes take effect.

Senator RUSTON: I certainly understand that. When was this table that I've got here compiled?

Ms Gleeson: I'm not sure what table you're looking at.

Senator RUSTON: It's the same table you're looking at, because you're using exactly the same figures.

Ms Gleeson: I've only got the 2023-24 and 2024-25 numbers in front of me.

Ms Strapp: Are you able to share that table with us so we can see?

Senator RUSTON: Yes, sure.

CHAIR: Are you sharing, or are you seeking to table?

Senator RUSTON: No, I'm going to share. I don't want all of you to have all my questions, because then you'll know how to answer them!

Senator Gallagher: Where'd you get the table from? Is it from a published document, or is it—

Senator RUSTON: Yes. It's on the health.gov.au website, and it's called 'foi-3902-release-documents-question-time-briefs.pdf'.

CHAIR: The officials are nodding. Does that mean you have the document?

Mr Lye: We don't have it.

Senator Gallagher: We might be able to retrieve it, but it's not here right now.

Senator RUSTON: Alright. Well, I'd just be really interested, in terms of the development of these workforce numbers, to understand how we've got to them. Clearly we're not disputing the numbers.

Mr Lye: We're happy to come back on notice to give you the modelling, if you like, or the formula of how we've got from the baseline in 2020, when the survey was done, to that 2023-24 baseline figure, before we add the policy commitments and before we add the treatments. We can give you the methodology for that so you can see that we're taking into account various things.

Senator RUSTON: During the debate on the implementing care reform bill in the Senate, Senator Watt had carriage on behalf of the minister, and I asked him about these numbers and whether there'd been any sort of pandemic reassessment or remodelling in relation to the stocktake of numbers of current nurses that were needed in the sector, and he said that there was a health workforce report that was due in November.

Ms Strapp: Yes, I believe he was referring to the quarterly financial reports which will give us up-to-date data on the number of staff in each facility and also the care minutes. They're care-minutes targets, so we can look at how many staff there are, broken down by direct care workforce and other workforce, and then what their current care-minutes target is and what they are currently delivering, and then we can look at what the gap is. We can use that data that we're getting. We only received that quarterly financial report last Friday, on the 4th. We can use that to look at where each facility is sitting in terms of their care minutes and what the gap is with the staff that they've got.

Senator RUSTON: On that basis, I can assume you would have had one in August?

Ms Strapp: No. This quarterly financial report is a new report, and this'll be the first time that we'll get this report from providers.

Senator RUSTON: Okay. So you should be in a reasonable position to be able to update your numbers over the coming weeks, given that you've got this report? By February, when we come back again, you should have a much clearer understanding.

Ms Strapp: Yes. Correct.

Senator RUSTON: Okay, that's great. Will this be tabled? Will this report be a publicly available report?

Ms Strapp: What we plan to do with the quarterly financial report is that we'll be releasing a quarterly financial snapshot, which will include some of that information at a sector level, and that's due to be released in February of next year.

Senator RUSTON: When you say a summary, what's the rationale behind not releasing the whole report? Is there information in there that's challenging?

Ms Strapp: You mean every report from every provider in the quarterly financial report?

Senator RUSTON: No, no. You must collate that into a final report.

Ms Strapp: Yes.

Senator RUSTON: So you're not releasing the final report?

Ms Strapp: That will be the final report, but I guess I call it a snapshot because it won't be a huge document. We release every year—and we've just released it—a financial report on the aged-care sector. This is a quarterly report that will be shorter, so I use the term 'snapshot'. The full report will be included; we're just not intending for it to be a really long report.

Senator RUSTON: Okay. Another comment that Senator Watt made during that passage of that particular bill was that the sector will be relying on immigration to assist providers to meet their legislative requirements. Do you have a figure in terms of that 11,760 that is likely to be achieved through a migration program specific to the care sector for nurses and nurse practitioners?

Ms Strapp: I think we are estimating around 1,800 registered nurses. I'll just have to check whether we've got a similar figure for PCWs. I think we do.

Mr Lye: But one comment I'd make about that is that I think what we're doing, based on recent experience, is a straight line out on migration. So that will be a very conservative estimate on our part in terms of the things that contribute to meet the gap, the 11,800. So we've got a whole lot of treatments. Migration is one of those things.

Senator RUSTON: I get that.

Mr Lye: So the 1,800 is a conservative figure that we've put in.

Senator RUSTON: So there are 1,800 RNs and 1,800 nurse practitioners.

Ms Gleeson: We often combine registered nurses and nurse practitioners into the one category.

Senator RUSTON: So is it 1,800 in total?

Ms Gleeson: Yes.

Senator RUSTON: Okay. That's fine. Mr Lye, I think you said on Tuesday that you believe that the pay rise had been modelled at possibly 5,000 additional entries as a result of the 15 per cent pay rise?

Mr Lye: No, I think I said to you that we thought that, after you apply the treatments to that 11,800 figure, the gap in RNs that we need to find is between 4,000 and 6,000.

Senator RUSTON: So you are sort of halving the amount by the treatments that you've got on foot at the moment, which would include the migration, the 15 per cent and other treatments that you may put.

Mr Lye: And other programs which we can run through. I think it useful just to sort of mention them.

Senator RUSTON: Sure.

Ms Gleeson: Firstly, with the announcement of the additional Commonwealth funded university places, so the total announcement's 20,000 of those, with 2,600 set aside for nursing places. For nursing students, as well, we are implementing a clinical placements program to facilitate high-quality placements in aged care, to encourage them to return to the sector after they've completed their degrees. So we've got 1,400 places in that program at the moment. To support career pathways for nurses, we've got the aged-care scholarships program, which provides opportunities for nurses to do postgraduate qualifications and also for enrolled nurses to become registered nurses if that's what they would like to do.

Senator RUSTON: Have you broken down the kinds of numbers that you think you're likely to generate and when? Obviously, if you're talking about a new student going in, there's a time lag, whereas existing students—so, in each of these initiatives, have you got a number of additional aged-care nurses that there might be?

Ms Gleeson: Yes, we have made estimates around that. We acknowledge there is some complexity with time lags in terms of the university pipeline, but we have put numbers against each of those.

Ms Strapp: That's right. I think we mentioned the 1,800. We think the combined impact of all those programs—this is for registered nurses—is around 800. That is an additional 800 nurses through those combined programs that Ms Gleeson just talked about.

Senator RUSTON: Okay, that's great. In your programs that you've put in place to try and encourage people into nursing in aged care, what consideration was applied in terms of the modelling of the likelihood of the nurses who would otherwise have gone into the healthcare sector who now may be attracted to go into the aged-care sector? Has there been any modelling of a potential detrimental impact to the supply of nurses into other sectors because of the initiatives you're putting into this sector, or is there a whole-of-nurse-workforce strategy in place?

Mr Lye: I think some of our initiatives are quarantined elements of larger programs which are where we believe people will come to aged care. So there is a larger overall effort. So I don't know that we would be concerned that there's going to be a detrimental impact on the health sector.

Senator RUSTON: Professor Murphy, I just wondered, given that you've largely got responsibility across the whole of the nursing workforce, whether there's any opportunity to be able to provide the same sort of data that we're talking about, in terms of vacancies, demands and applications, about what you think the overall impact on the nursing workforce is going forward and what the shortfall is and where it's likely to be?

Prof. Murphy: I think we mentioned this earlier when the workforce people were here. There's a national nursing strategy, and part of that is a nursing supply-and-demand modelling. It's quite complicated because much of the nursing data is held by hospitals—state and territory hospitals, private hospitals et cetera. So, unlike with medical practitioners, where we have pretty good data, we have to get that data from our jurisdictional colleagues. But they are on board with that stuff, and the project is happening now. I don't think it has got the answers you want yet, but that is definitely work that's underway at the moment.

CHAIR: Senator Ruston, are you happy for me to share the call around at this point?

Senator RUSTON: Sure.

CHAIR: Have you got a few more questions on this section?

Senator RUSTON: No, I'm happy to go with the flow.

CHAIR: Alright. Senator Pratt had a few questions.

Senator PRATT: I've got some questions—

CHAIR: Sorry, Senator Pratt. I've done this a few times! I need to make a statement.

Senator PRATT: No worries.

CHAIR: Just to confirm, we've had informal conversations with the department. The committee resolved earlier to release outcome 1 witnesses at the end of our questions for them. We resolved to consider outcome 2 as spillover at a later date. That is what the committee is expecting to do. That's just to bring everyone up to date. Thank you, Senator Pratt.

Senator PRATT: The Aged Care Amendment (Implementing Care Reform) Bill 2022, which has recently passed parliament, requires aged-care homes to have nurses on site 24 hours a day, seven days a week. When's that requirement active? What's the expected benefit to residents in aged-care homes?

Dr Hartland: That requirement is active from July 2023. The principal benefits are around better access to the types of services that a registered nurse can provide—that is, monitoring a patient's wellbeing and being able to give advice if the patient's health deteriorates at short notice. So it's about access and preparation, preventing avoidable hospitalisations and also supervising staff.

Senator PRATT: It certainly fits with the needs of many constituents that I've spoken to. Does it apply to all aged-care homes?

Dr Hartland: Yes, the requirement does apply to all aged-care homes, but there is a provision for some very limited exemptions for homes in rural and remote areas.

Senator PRATT: In terms of those workforce shortages, which are current and quite needy, how do you go about balancing the need for clinical care despite the need for an exemption?

Dr Hartland: There are a couple of elements to that. The first thing is that the exemptions that are available are very strictly limited; therefore, in small residential facilities with 30 beds or less in what we call the Triple M5 to M7 areas—I think 'rural and remote' is a good summary of that—the exemptions are time limited. About 191 providers could be eligible, which would cover just over 3,000 residents. Having said that, we don't expect that all of those facilities that are eligible would necessarily want an exemption.

Senator PRATT: Yes, they'll recruit.

Dr Hartland: Some will wish to make an effort to supply nurses. The principal aim of the exemption process is to ensure that facilities that would have a lot of difficulty approaching a nurse don't fall foul of the requirements of the act and consider exiting the industry.

Senator PRATT: How long is the exemption valid for?

Dr Hartland: It's for 12 months.

Mr Lye: There's also a supplement that will be provided to smaller residential facilities with less than 60 beds.

Senator PRATT: Great.

Dr Hartland: That's right. We should have started with information on the supplement. Mr Lye is correct.

Senator PRATT: No, I've understood your answers very well. So—

Dr Hartland: The other thing, just to complete the answer about the exemption—excuse me for interrupting you—is that facilities will need to sign a statement confirming that they have in place processes to deliver safe care. So there are a couple of safeguards built into that exemption process if they choose to apply for it.

Senator PRATT: I guess it is just like what happens in child care currently.

Mr Lye: Just the last thing, probably, for completeness, is that we're going to do some work to look at safe models of care. For example, some of our providers have raised the issue about whether it would be appropriate to have an RN on call supervising an EN in a facility, and so we have undertaken to do some study to get some clinical advice around how to provide high-quality safe care with a model that might be slightly different to that approach. I think that will be important.

Senator PRATT: So it could, for example, have an RN on call and/or letting families know, letting relatives know, if there is an incident where there is not an RN on site. I'm sure there are lots of ways that you can do that. Clearly that was our election commitment. It was a commitment to eventually meeting the 24-hours, seven days a week, nursing standard, even if there are a small number that don't initially. In that context, what consultation has the department undertaken in developing the detail and delegated legislation for that exemption?

Dr Hartland: Mr Richardson has been handling the measure, and he will be able to talk to you about the consultation arrangements.

Mr Richardson: We have undertaken extensive consultation. I don't have a list in front of me of all the organisations we've consulted with. I think we may have provided it at another hearing previously, so it is on the record. But we've consulted extensively with the sector.

Senator PRATT: And that's going to continue. Will we get to see the delegated legislation before it's registered?

Mr Richardson: The intent is that we would have an exposure draft of the subordinate legislation early in the new year.

Senator PRATT: That's subordinate to the legislation we've already passed. The original legislation came before this committee, and the subordinate legislation will go before the delegated legislation committee, who will get in touch with this committee if they need to. What enforcement action will the quality and safety commission take if an aged-care home doesn't have nurses on site and it doesn't have an exemption?

Dr Hartland: There are a number of compliance layers to this measure. It doesn't all rely on the quality and safety commission. There are also reporting requirements for this measure. Providers will be required to report if they don't have a nurse on site and they don't have an exemption. If they do report that they don't have a nurse on site, the supplement won't be paid. We also have an audit process that we're developing to check whether their reports are accurate, and there will be access to complaints, which probably takes us to Ms Anderson's role.

Ms Anderson: Dr Hartland has covered most of the territory. The subordinate legislation will be instructive in terms of providing some of the detail on which we will design our methodology. But we already have a number of compliance and enforcement tools that we will make good use of. Dr Hartland has spoken about the fundamental requirement for providers to report. The first area of compliance is failure to report. If they're late reporting, then that needs to be understood. If they fail to report, that needs to be understood. That could fold into a larger risk-profiling exercise that the department and the commission would undertake, possibly together. We are a risk based proportionate regulator. We would understand a service or provider not just in relation to this particular piece of data, which might be the number of shifts for which they did not have an RN cover. We would put that alongside the other things we know about that service or that provider and then take measured steps to obtain any further information which might be necessary. It might be a misreporting error. It could be that there are a range of good reasons where we would satisfy ourselves the provider has managed the risk and there won't be a recurrence. If we are less than satisfied, we may push it further and take some regulatory action in relation to that provider, in order that they would ensure it did not happen again.

Senator PRATT: That's terrific to understand in terms of the systemic and holistic approach to that enforcement, so thank you. Thank you, Chair.

CHAIR: Thank you, Senator Pratt. Senator Rice.

Senator RICE: Thank you. I'll be continuing with aged-care reforms and going on to the Support at Home reforms that we touched on in the last bracket. I want to start with the current status of the Support at Home reforms, and whether there's more consultation being undertaken on them?

Dr Hartland: Yes, there is. We released a discussion paper on 18 October, and that's open until 25 November. We're currently in consultation on the elements of that discussion paper widely with the sector. There'll also be future consultation arrangements around what we would call a co-design process with the care management function, which is new to the program. That's an existing function of the home-care package program, but we feel that care management currently in that program is not working in the way that it should, so we're trying to co-design that with the sector. There's a co-design process around an assistive technology and home modification scheme that's occurred that we're working through. We've consulted on the funding model and talked with various groups across the sector about IT and other aspects of the program. So there's quite an active process of consultation going on around the program.

Senator RICE: In terms of some of the directions you are heading in in relation to that discussion paper, how do they differ from where we were at under the previous government?

Dr Hartland: It's a good question. I've had occasion to speak about that at conferences. What I've said at conferences is that, in terms of the feedback on the discussion paper, there were some elements that didn't attract a lot of comment. In terms of the idea of better assessment and a new way of understanding people's entitlement, there wasn't a lot of consultation about that. There's still work to be done on it. There were some things like reforming case management and allowing consumers more choice which were part of the previous approach which were accepted. They need more work. There was a lot of feedback around the flexibility of the model that was proposed in January and that it might not be able to be adjusted as the needs of older Australians changed—and they can change quite quickly. There was significant feedback from some of the current CHSP providers, particularly transport groups, social support, meals and, to some degree, respite—although not quite as strongly—about the move to a fee-for-service model, which wasn't popular, I think you'd say. The current discussion paper proposes some new arrangements and asks for views about how to address that and signals that that aspect—a full fee-for-service model—would be significantly changed in any future proposal.

Senator RICE: Are you looking at extending the same approach under the AN-ACC funding model for residential aged care—potentially a version of that across at-home care?

Dr Hartland: My favourite topic! No, we've assessed a full case-mix model a couple of times in this consultation process but, generally, for what you would think of as the home-care package segment of aged care. There's a group that have proposed a funding model built around weighted activity units and a national price for CHSP services. That's not currently being developed by the department; we don't think it works very well. But some aspects of the issues that they were raising in developing that model have been taken on board in the discussion paper.

Senator RICE: You've got the discussion paper out at the moment. Until when is that open for consultation?

Dr Hartland: Until 25 November. That's quite a short period, but we need it to feed into some considerations within government that we're working with our colleagues in the central agencies on. Having said that, it was our experience last time around—and every time we release a paper—that there are people who come back to you post the consultation paper and we would always listen to them. If somebody gave me a note on 26 November, it's not like I wouldn't read it. So the answer to your question is 25 November, but with some leniency.

Senator RICE: Would you see yourself having some more targeted conversations and consultations with key stakeholders, once you've got some new proposals that have come out of the feedback on that?

Dr Hartland: There will be a process of discussing it with government, and that will probably lead to some more fully formed proposals, and, in any event, there are some things that, independent of all that, we will need to work on.

Mr Lye: The government put some money aside in the October budget—around $23.1 million—to do some other work around the new program: a large-scale trial of an integrated assessment tool, the establishment of a service list or advisory body and commissioning the new Independent Health and Aged Care Pricing Authority to undertake a pricing study. So there are a range of other activities happening, as Dr Hartland is alluding to, in parallel to that consultation process.

Senator RICE: You've got your discussion paper out in November. There'll be some further discussions with government and, potentially, with stakeholders as well, once you've got some proposed ways forwards?

Dr Hartland: Yes, I think you observed earlier that aged care is a diverse sector. I'm pretty sure that the feedback we get will point in different directions, and then we'll need to resolve issues that arise from that.

Senator RICE: Would you be looking at having legislation that's a component of the new aged-care act, or would there be separate legislation?

Dr Hartland: It would be a component of the act. So, in one sense, what we are doing is one of the consultation elements for the new act, because it feeds into the act.

Senator RICE: I've certainly heard reports and heard from stakeholders that the uncertainty of what is happening with at-home care has made it hard for providers to continue on a sustainable basis. I'm interested to know what support you're providing to providers, given that ongoing uncertainty?

Dr Hartland: It's obviously an issue. The start of the program is still some time off, and one aspect of what we will be doing is extending CHSP arrangements. That process is about to start, so that would give those providers a greater degree of certainty about their contracts for the 2023-24 financial year. At the moment, the best certainty we can give them is being open about where we think the reform directions are, so we're consulting pretty intensively, but we don't have a final decision, and, of course, as you referenced, there are different voices about what the final process should look like. A provider will be listening to that and still not have certainty about

the detail, and they're very hungry for detail. We're working as hard as we can to get them that certainty, but we still need to design the program in a consultative way.

Senator RICE: Presumably, as per the previous discussion, we're not going to have legislation that this will be a component of passed through the parliament until sometime in probably the last quarter, let's say, of next year?

Mr Lye: The second half of next year.

Senator RICE: Regardless, you're going to be going into 2023-24 financial year and there's not going to be something ready to go at the beginning of the 2023-24 financial year.

Mr Lye: No, and we expect—notwithstanding the amount of consultation and the fact that a lot of these providers and consumers have obviously had a voice during the royal commission itself—that people want to see what the final outcome looks like. We expect to get extensive feedback once they see that, in the overall new aged-care act, in an exposure sense.

Senator RICE: A further element of home care goes to the implications of the Fair Work Commission decision that specifies a two-hour shift for workers. We know that there has been quite a lot of upheaval and people's care being upset because of that—my mother's included. What do you feel have been the implications for homecare packages of that decision by the Fair Work Commission, and what steps is this government taking to support providers because of that?

Dr Hartland: When this first arose, we talked with the peaks and with providers to understand the impact and issued some advice to them. This seems to have quietened down significantly over the last six months. I hear much less. We did see correspondence on it. This was a matter which by and large got solved by some good sense on the ground with providers. There may still be issues, and of course if there's a consumer that's unhappy, we're always willing to hear about it. But the essence of our advice was that while the Fair Work Commission ruling was that they had to offer workers a two-hour shift, that did not require that worker to spend two hours with a particular resident. So the remediation of that was about some good-sense scheduling of workforce so that a person could see a couple of people. If they had two people who needed one hour and they were quite close together—

Senator RICE: And paying for their travel, which is a very sensible and reasonable thing to do, rather than some providers who weren't paying for travel.

Dr Hartland: This seemed to be an issue that caught fire on the basis of erroneous interpretation or advice that now seems to have quietened down. But things do tend to catch fire again, so if there are consumers that are still feeling that they are not being fairly dealt with, we're happy to have that relayed.

Senator RICE: My mother has a whole amalgam of different services. That's just the way that it's working best for her. When she was only having one hour of homecare support, she now has a couple of afternoons where she has got two hours and other days where she hasn't got anything still, so it is still a bit messy.

Mr Lye: Frankly, that raises that other behavioural issue that we saw, which is that there should be a consent to change a plan. We certainly saw instances where consumers were coming forward to say that the provider hadn't done that properly. So that's another thing, obviously, that we followed up.

Senator RUSTON: Following on on the exemption discussion that you were having with Senator Pratt earlier, Dr Hartland, you made the comment that exemptions would be strictly restricted, that they were largely going to be restricted MMM 5 to7, which were remote and very rural, but they were time-limited and you believed about 191 providers would be eligible for this exemption. Can you confirm that's all correct?

Dr Hartland: Could I rephrase something? It's not largely restricted to, it's entirely restricted to MMM 5 to7, and for residential care facilities with less than 30 beds. It's only available in five and seven and only available to small residential facilities with 30 beds or less.

Senator RUSTON: Can I take from that that you're quite a long way down the track in terms of the design of the exemption eligibility criteria and process for application?

Dr Hartland: Yes.

Senator RUSTON: The Secretary, or maybe it was you, Mr Lye, made some comments around safe models of care. Are those safe models of care that look at the possibility of having an RN on call and an EN on site part of the exemption process, or are they outside the exemption process?

Mr Lye: It's a separate process. Mr Richardson might speak to that. I gave that example and I should say that I'm not an expert on this either, so I wouldn't want to hold that out as the model. We're going to ask people with expertise what a safe model might look like.

Senator RUSTON: I'm trying to put this in the context of the 24/7 commitment. Can I assume that the models of care that are being looked at are to still deliver the same level of care but by a model that may not necessarily strictly adhere to the 24/7 requirement?

Mr Richardson: As has been explained, the exemptions are limited to areas where there are chronic issues, or there have been in the past, in terms of workforce shortages. We will be undertaking a consultancy to look at clinically alternative models of care. As you have articulated, that may include things like nurses being on call. It may include telehealth and those sorts of arrangements as solutions for those types of issues moving forward.

Senator RUSTON: Are these models of care a temporary process until the facility is able to ensure 24/7, or are they a model that may be applicable in the longer term?

Mr Richardson: They're a model that may be applicable in the longer term. We will work with a body with expertise to be able to provide the advice on what would be a clinically safe model.

Senator RUSTON: Who would that be?

Mr Richardson: We're looking at undertaking consultancy with a university.

Senator RUSTON: You're not looking at, say, AHPRA, or one those?

Mr Richardson: No. We're using a whole-of-government panel and going to some universities.

Senator RUSTON: So you could suggest that the commitment for 24/7 nurses in every nursing home in Australia, there is a deviation from that in terms of what you have said to me. Because if we're looking to alternative models—I'm not being critical of your—

Dr Hartland: At the moment we see the alternative models as only applying to that small exemption group.

Senator RUSTON: Can I take a step back, Mr Lye. I asked in a question a minute ago, was this applicable only to the MMM 5 to 7s, and you said no, and now you've just said that it is. Could we get some clarity on which of the two statements is correct?

Mr Richardson: The alternative models of care don't exist at the moment.

Senator RUSTON: That wasn't my question. I said, will the ability for an alternative model of care be restricted to those that are in the MMM 5 to 7 exemption area, or will they be more broadly available. You said they were more broadly available, and you've just said that they are only available to the MMM 5 to7s with exemptions.

Mr Richardson: I apologise if I inferred it was broadly available. That would be a future government decision. We need to undertake that consultancy first. How that would apply, where it would apply, would be a future decision.

Mr Lye: I think Mr Richardson framed his answer in the sense that obviously the exemption applies to small facilities in MMM5 to MMM7 for a time-limited period. We're doing the study. Mr Richardson said those are the areas where we know we have previously had chronic workforce shortages. That is the area where you would be concerned that possibly after the 12-month exemption we might still have a problem or an issue that we need to solve. That's what the study will look at. That is clearly the context.

Senator Gallagher: I think I'm going to jump in here. I've been very patient for more than half an hour listening to this and the concern from Senator Ruston about the workforce shortages in aged care. I would also say that all of the work that's being done now is because of the neglect of nine years of failing to deal with the workforce pressures in aged care. So I'm not going to sit here tonight, because I can see where this is heading, with criticism from you about the work that's being done to fix up the mess that you left in aged care.

Senator RUSTON: Chair, could I just ask—

CHAIR: Senator Askew, are you seeking to call a point of water? I heard you call 'relevance' across the table. Are you seeking a point of order or not?

Senator Gallagher: I was being very relevant. I am mindful that it's Thursday night of estimates and everyone would like to get out of here. There's been a long filibuster all day and everybody's tired and cranky, including me.

Senator RUSTON: A point of order, please. My point of order is on the fact that I have sat here the entire day, as has every other member of this committee, asking relevant questions, and then to be lectured at at the end of the night—

CHAIR: Senator Ruston, this isn't a point of order.

Senator RUSTON: so would it be possible for us to get back to questioning?

Senator Gallagher: No, I just want to put on the record the total lack of credibility you have in this space.

Senator RUSTON: I have not been filibustering.

Senator Gallagher: You have been. All day, you've been filibustering. Everyone in the building knows you've all been filibustering. Everyone's been talking about it.

CHAIR: Senator Ruston, Minister Gallagher—

Senator Gallagher: It's obvious what's been happening today.

CHAIR: I have the call, thank you. It facilitates the work of the committee if we can return to our process of asking questions and giving answers, and all of us listening to each other as we do that. Senator Ruston, you have the call.

Senator RUSTON: If I can return to my line of questioning that I can assure you isn't filibustering, and I am genuinely interested in the answers to these questions—

Senator Gallagher: It's a shame you weren't as genuinely interested when you were in government for nine years. And I'll leave it there.

Senator RUSTON: Maybe you should get another lolly.

CHAIR: Senator Ruston, you have the call. It's 8.21. Everyone's doing their best. Let's get on with it.

Senator RUSTON: I'm just trying to get an understanding around the exceptions. I can absolutely assure you that I have no issue whatsoever with the proposal about providing 24/7 care for residents in aged-care facilities. I have no problem with care minutes. I'm entirely supportive of this whole thing, so I'll get that on the record. But what I am interested in is making sure that, with the best of intentions to provide that care, we don't end up with the unintended consequences of exemptions not being available to facilities that genuinely need them, which of course would result in them having to close because no aged-care facility wants to operate in breach of the requirements. So can you just expand on MM 5 to MM 7. How many aged-care facilities of under 30 residents exist in MM 5 to MM 7 areas?

Dr Hartland: It's 191 providers. That's facilities.

Senator RUSTON: So every single aged-care facility in an MM 5 to MM 7 area with fewer than 30 residents is likely to apply?

Dr Hartland: No. Sorry if I wasn't clear before. That's the number that would be eligible to apply. But I thought I said before that we didn't expect that all of them would apply for an exemption.

Senator RUSTON: Do you have an idea of how many will apply?

Dr Hartland: I'm sorry, I don't. Mr Richardson?

Mr Richardson: No, not until we go through that process, Senator.

Senator RUSTON: Sure. How many aged-care facilities would there be in total in MM 5 to MM 7 areas?

Mr Richardson: I would have to take that on notice for a precise number, but I think it would be close to about 400.

Senator RUSTON: Could you also, while you're taking that on notice, provide me with advice on how many aged-care facilities with under 30 residents would exist in other MM areas. I'm particularly interested in MM 3 to MM 5. Just as an example, if I'm an aged-care provider with 35 beds in an MM 7, are you saying that I can't apply? There is no scope for me to apply?

Dr Hartland: That's right. The exemption, as we said, has been tightly drawn. It's for small facilities in MM 5 to MM 7. There are probably about 350 to 400. We'll give it to you on notice. It's for very small facilities across all MM levels. That would include the 191. My mental maths isn't good enough to give it to you. I've got to table it. I can't add it up quickly enough! We'll give it to you on notice.

Senator RUSTON: That's okay. On notice is good.

Mr Lye: The supplement process that we talked about applies across all the MMs, and that's under 60 beds.

Senator RUSTON: So any nursing home anywhere in Australia with under 60 beds will get the supplement?

Mr Lye: That's right. All of those in MM 1 to MM 5 that are 30 beds will be eligible for the supplement to help them get to 24/7 nursing.

Senator RUSTON: So MM 5s to MM 7s will be able to get exemptions, and MM 1s to MM 4s will be able to get the supplement, or is the supplement going to the MM 5s to MM 7s as well?

Dr Hartland: All MM levels under 60 beds will have a supplement. If they choose to have an exemption, we don't pay the supplement, which would be logical—right?—because they don't have the cost. But if they don't have an exemption then they'll get the supplement.

Senator RUSTON: Is the supplement ongoing or just a one-off?

Dr Hartland: It's ongoing, and it's paid at different rates for MM 1 to MM 4 and then MM 5 to MM 7—and different rates for different sizes.

Senator RUSTON: During the legislation debate in the chamber, Minister Watt also said exemptions would be determined on a case-by-case basis. I'm trying to reconcile that comment with what you've just said. It sounds to me that that's not the case.

Dr Hartland: A provider will apply for an exemption and it will be determined.

Senator RUSTON: Thank you.

Senator RICE: I've tried in about three different places in the last couple of days with these questions on the cutting of funding to Palliative Care Australia, the peak body of palliative care. I know it's not in this outcome but the impact that that has on aged care is very significant. Did the department consider the impacts on aged care when defunding the peak body?

Prof. Murphy: I think the officials who look after that area aren't here at the moment.

Senator RICE: But the peak body has been defunded?

Prof. Murphy: There was a competitive process around peak body funding and there was a range of criteria, but I don't have those officials with me because they were allowed to go.

Senator RICE: I understand there was a focus on preventative health. If you're the peak body for palliative care, it's a bit hard to focus on preventative health. Nonetheless, did the department consider the impacts on aged care when defunding the peak body?

Prof. Murphy: There was a process that was gone through to decide which of the people that were awarded that peak body funding had a stronger or weaker case for it. It would be speculative to go through the details of that process without the relevant officials here.

Senator RICE: Did they consult aged-care stakeholders?

Prof. Murphy: I'd have to take that on notice.

Senator RICE: With reference to aged care and from the perspective of aged care, how are you going to implement the recommendations in respect of palliative care? The royal commission said:

High quality palliative care is essential to ensuring that an older person can live their life as fully and as comfortably as possible …

I'm sure we all agree with this. We have a peak body that is being defunded and that won't exist to draw expertise from.

Mr Lye: They're one stakeholder, obviously.

Senator RICE: They're the peak body for palliative care.

Mr Lye: I don't want to cast judgement because it's not my area. Sometimes we deal with peak bodies who are more or less effective, but we do have pretty developed stakeholder arrangements—in particular, the Council of Elders has been established in the National Aged Care Advisory Council. Palliative care is important to us in aged care, and we use those facilities as well as have regular discussions with senior officials in the state and territory governments who have a key role in palliative care. I don't think it changes our commitment to reach out to stakeholders to talk to them about issues in that space.

Senator RICE: You don't think it will have a gap in terms of—

Mr Lye: I can't comment. In fairness, I don't know the process that was undertaken.

Senator RICE: I don't either. All I know is you had a peak body for palliative care that had existed, that had brought together expertise and research and experts in palliative care, and that had funding and now does not have funding. I want to know what impact that's going to have in terms of the government's implementation of the recommendations of the royal commission to make sure palliative care is there at the forefront, and that workers are properly trained and all that expertise is there.

Senator Gallagher: If you go through a competitive process, which I understand was gone through, you don't usually consult with other stakeholders about the decisions you take; you go through the competitive process, as you know. In palliative care there are a range of providers. Peak bodies don't necessarily provide services. They

might provide a particular expertise. I know that here in the ACT there are a range of expert groups that provide palliative care services both into aged care and outside of that. I'm sure that was part of the consideration, as it would be, through a competitive grants process. I think it would be fair to get here the officials that are in a position to respond to that.

Prof. Murphy: As Mr Lye said, palliative care is an integral part of the whole aged-care sector. All good aged-care facilities will have palliative care approaches and palliative care training. That's one of the reasons we want more RNs in residential aged care, because they are often very expert in providing palliative care. It's a really important part of aged care; we completely agree with you. In fact, there's quite a lot of palliative care that happens in aged care; the good providers do it very well. I don't know that there's necessarily a relationship between that peak body funding, but, as the minister said, we can come back to you on the peak body.

Senator RICE: There's a reason for peak bodies. They bring together a sector, they bring together expertise in research, they enable you to draw upon that and they enable other parts of the sector to draw upon that expertise and research without it being through a provider or a particular segment in the sector.

Senator Gallagher: I can't reflect on the process because I haven't been briefed on it, but if you go through a competitive process that's what you engage in. Just because you're a particular group that does a particular thing, it doesn't necessarily guarantee you, in a general sense, access to funding.

Senator RICE: Again, I am not an expert on what the process was. But I have been told the criteria for the process had quite a good focus on preventative health, that being a really high criteria; if you're the palliative care peak body, that's not something you're going to score highly against. It just seems extraordinary, given the focus on good palliative care, to have the peak body defunded. Can I ask you to take on notice whether the department, the aged-care stakeholders, the aged care part of the department, was consulted in terms of this decision to defund the palliative care peak body.

Prof. Murphy: We'll take that on notice.

Senator RICE: I now want to talk about a person who was brought to my attention; I want to use this specific case to talk about something generally. This woman was approved for My Aged Care in November 2021, for someone to help her out once a fortnight with shopping assistance and domestic support. She can't bend or kneel due to problems. She was waiting a year for support and received nothing. She called some national organisations after My Aged Care told her there was nothing they could do, as they couldn't see any providers in her area to make a referral to. She lived in inner Brisbane. The advocacy organisers then gave her a large list of providers to ring to ask for support. She has contacted 17 of those providers, and not one has agreed to take her on to support her; only one was willing to put her name on a waiting list. What are we doing to address this issue of this lack of ability to meet people's basic needs? We're not even in a regional or rural area here; we're in inner Brisbane, where somebody needs help and can't get it.

Dr Hartland: I'm assuming from the description of the case that this woman was assessed as eligible for a CHSP service?

Senator RICE: I don't know whether it was CHSP or whether it was a level 1 package or something.

Dr Hartland: If it was the Home Care Packages Program, there has been considerable investment in that program over the last few years and the wait times have reduced very substantially. If it was in that program, then that would be unusual. I would be suspecting there was a system error. We would need to see the details of the case. If it was CHSP, the wait times to service in the CHSP program, in the broad, are quite quick; the median time to first service for new clients is 20 days. But there are some problems in some areas. I don't know whether Mr Herald would be able to give us some more details—Mr Herald?

Mr Herald: I'm sorry; I don't have the specific case numbers that you're talking about, and if—

Senator RICE: I am very happy to forward the details.

Mr Herald: And we can look into the specific case that it is.

Senator URQUHART: It might be better if you do that, because then he'll be talking more specifically.

Senator RICE: But I wanted to use it in the general. It's a specific case but, in general, it's indicative of a problem.

Mr Herald: Yes. If the individual in question is a Commonwealth Home Support Program recipient, it's a grant based program based on the number of providers that we issue grants to at any given point in time, and the availability of services varies, depending on demand and workforce availability at that point in time. Every situation and every location across the country is unique, so we would need to investigate the specific circumstances of this case. The general advice we provide is that, if there is excess demand for services out there,

there is available funding in our budget for providers to come to expand supply. What we're not seeing necessarily across the board is providers coming and asking for additional money for other reasons—for instance, workforce and whatnot.

Senator RICE: Are you suggesting that these 17 providers she contacted—if it is a CHSP—who said they couldn't take her on should be coming to you to ask for more funding?

Mr Herald: Those providers can come to us to ask for more funding. Alternatively, CHSP is designed to access one or two services a fortnight or a month, and people come in and leave the program reasonably regularly. They may have service availability coming in soon.

Senator RICE: There was only one that was willing to put her on a waiting list. It would seem, if there were 17 providers and only one was willing to put her on a waiting list, that there was a severe undersupply of services in the area.

Mr Herald: Yes.

Dr Hartland: Sorry, Senator. What was the service type? Did you mention that? If you did, I missed it.

Senator RICE: She was approved for My Aged Care in November 2021, which would imply a package rather than CHSP.

Mr Lye: Obviously, we'd like to take those details to follow it up, but what Mr Herald is saying is that we would expect that, where our CHSP providers are finding that demand for their local services is exceeding their supply, they would then come to us and say, 'We want to expand.' And we would work with them to do that. That's one of the limitations of the current model which we're looking to reform.

I think the second thing to say, if she went to 17 services and wasn't getting access—I think you mentioned advocacy—is that certainly one of the things in the reforms that we are paying attention to is improving wayfinding for people and also improving support for people who might need assistance to get a service. It's a suspicion that, if someone has been to 17 services without success, that's a person that might need help from an independent person to access a service.

Senator RICE: Certainly. She called OPAN and the Queensland ADA. I quote: 'After My Aged Care told us there was nothing they could do as they couldn't see any providers in her area to make a referral to. The advocacy organisations sent out a large list of providers to ring to ask for support.' There were 17 that she rang, and only one was willing to put her on the waiting list.

Mr Lye: You would be aware, though, that we are dramatically expanding the operation of OPAN and the number of independent advocates in the system for precisely this reason, because some people need a greater level of support to secure a service than others. They play a very important role in doing that. It's hard to know, without the details of the case, but I do think there are some things, as part of the reforms, that will address this specific situation and try to improve on it. As Dr Hartland said, we're also dramatically increasing the availability of places for people who live at home, and obviously that will go in large part to the adequacy and the timeliness of the service that people get.

Mr Herald: Senator, if I can get the details I'll get the case team to look into.

Senator RICE: A few months ago, somebody put their mother into respite care on a Wednesday and was told on the Friday that there was a multi-day COVID outbreak under way which the aged-care facility knew about when they admitted his mother. This person was obviously incredibly concerned for his mother. What should have happened? How was something like that able to happen? Is there a requirement for aged-care providers to notify people who are visiting or being admitted that there's a COVID outbreak?

Mr Lye: The first thing to say is that I don't they should have been accepting people in that circumstance.

Senator RICE: No.

Mr Lye: It probably goes to the line of what the chair is raising.

Ms Grinbergs: Our expectation would be that a provider, in the instance that they were experiencing an outbreak, would be taking the appropriate precautions to manage that outbreak. In those instances, that would mean not accepting new entrants to a facility, regardless of whether it was respite or a new entrant for care, without appropriate consideration and mitigations in place.

Senator RICE: Is it specified that that's the mandatory approach, or is it a grey area where this provider could say, 'I don't actually have to do that'?

Ms Grinbergs: As the pandemic has progressed, we have seen adjustments in various directions, particularly in those public health directions that are set by individual jurisdictions, in terms of restrictions on entry to a

facility. Those have been modified over time. We are now in a different circumstance in the pandemic, and it is, effectively, a risk-based decision for a provider going forward. Most of those restrictions have now been walked back by individual jurisdictions. For example, there are no longer restrictions on visitation during the course of an outbreak, but the expectation is that appropriate precautions are undertaken to protect residents, visitors and the workforce.

Mr Lye: It may be that there would be a facility with cottage accommodation or separate wings who could safely separate people and eliminate the risk of spreading COVID. We don't know the case here, but it doesn't seem plausible that a respite facility could meet that criteria, and if they can't then they shouldn't have accepted people.

Senator RICE: I note Ms Anderson has come to the table. What should people be able to do? What could they do? What would the commission have done in those circumstances?

Ms Anderson: Perhaps I can start at a slightly different point. If someone were placed in that circumstance and they wanted to lodge a complaint, we would take it very seriously. We would approach the provider and say, 'What's happening, and why did you not disclose this to that individual on their way in?' That's just plain common courtesy. It's also treating the consumer with dignity and respect. Whether we would find them in breach, and there would be a noncompliance finding, is a moot point, and we would have to look at the particular circumstances, but I think it's disrespectful. I think they owe the consumer and the family of the consumer far more than they gave. I think there would be a justifiable complaint that we would act on, on the consumer's part.

Senator RICE: What would the consequences then be to that service? You can say they're not being courteous and they're being disrespectful, but if you're saying you don't know if they would have been noncompliant, what would the consequences be to that provider?

Ms Anderson: That's the essence of it. We would have to determine what level of mitigation was in place, how extensive the outbreak was, whether it was a single consumer and that consumer was isolated—the level of risk may actually be quite low overall, but the failure to disclose is, I think, significant, and we would certainly hold the provider to account for that.

There may be extenuating circumstances. There's always the possibility that, on the particular day this individual arrived or booked, the person who would normally disclose this was unavailable. If they're one-off, and the provider can indicate through evidence that it was an isolated circumstance then we might say, 'Just don't do it again.' But if it is part of the pattern, and we have had other complaints or the provider cannot give us a satisfactory accounting of why it occurred, then there may be other courses of action available to us—including, for example, issuing a direction that they revise their plan for continuous improvement, paying particular attention to providing full information to those who are booking for respite.

Senator RICE: Beyond revising their plan, would there be any consequences or penalties to that provider?

Ms Anderson: As a risk-based regulator, we are always attentive to the number of factors that attach to a particular action. I cannot give you a categorical answer to that without elaborating on the particular circumstance of this case.

Senator RICE: There's another case that I'm going to bring to your attention when I get my next go.

Senator RUSTON: Could you provide on notice the schedule of the supplement payments that you were referring to for the aged-care facilities under 60 residents? You said that there were different rates paid for different facilities and areas; is it possible to get that?

Dr Hartland: Yes, I believe they are on our website.

Senator RUSTON: I just tried to look them up, but I couldn't find them—that's not to say they're not there, because I'm not the greatest googler. In the workforce survey that was undertaken, it said that 20 per cent of aged-care facilities reported that they didn't currently have a nurse onsite 24/7. Of those 20 per cent, how many will be picked up in the exemption?

Dr Hartland: We can probably do the calculation.

Senator RUSTON: I would be interested to know, of that number—because it is significantly more than the 191—where they were, what they looked like and what their make-up was.

Mr Lye: I'm not sure if we have the information about the location of the 80 per cent, but I have a vague memory that the geographic distribution wasn't too bad. I will come back on notice.

Senator RUSTON: Have you consulted on the model that you have put forward tonight so far, or is that something that you will be doing shortly?

Dr Hartland: There have been some working groups that have assisted us in the design of AN-ACC that we have done some consultation with, but we haven't had a broad consultation on this.

Mr Richardson: We have consulted extensively. We have provided a previous hearing a list of the bodies that we have consulted with. I don't have the full list with me at the moment, but I'm happy to take that on notice and provide that again.

Senator RUSTON: Could you do that specifically in relation to your model of exemption? I'm only asking about the MM5-7 decision under 30.

Mr Richardson: Yes, I can give you a list of bodies we have consulted with on that.

Senator RUSTON: I asked on notice when one of the bills was going through if I could be provided with a list of all the rural, regional and remote nursing homes that had been visited personally by the minister. I didn't receive that. Was that request ever passed back to you?

Dr Hartland: We don't know the minister's diary.

Senator RUSTON: You don't provide the minister with a briefing?

Dr Hartland: We don't manage the minister's diary.

Senator RUSTON: It was a genuine—

Senator Gallagher: I know she has been very active in the aged-care sector. If you look at her social media account, you can see how many aged-care facilities she has visited. I would guess it's a lot more than under the previous administration, considering the output that she's managing to deliver in five months compared to the nine years of the former administration.

Senator RUSTON: Are you able to provide that information? I don't expect you to know it. Is it possible to get that information?

Senator Gallagher: I will consult with the minister's office and see what can be provided, but my remarks are accurate. I have no doubt that she has visited more than the former aged-care minister did.

Senator RUSTON: That wasn't my question. My question was—

Senator Gallagher: I'm making a point, because it's quite difficult to sit here and listen to the concern from the former government about what's happening in aged care when you had nine years of not dealing with it.

Senator RUSTON: Minister, we're going to be here for a very long time if you keep this up.

Senator Gallagher: Well, I'm happy to be. I'm here nine to 11 every day, so it doesn't make a difference to me.

Senator RUSTON: If you could take on notice whether you could get that information for me, that would be appreciated, because I had asked for it and hadn't received it. Actually, talking about having asked for information and not having received it, Professor Murphy, were you able to get that information in relation to those code of conduct breaches I asked about earlier?

Prof. Murphy: Mr Wann can provide an update on that.

Mr Wann: Since 1 July 2021, the department has received three complaints from external parties alleging departmental staff have breached the APS Code of Conduct. We have engaged external investigators for three: Clayton Utz for two matters and Sparke Helmore for the third. To provide, though, any further information at this stage would be inappropriate, as all three investigations are ongoing.

Senator RUSTON: So you can't advise whether any of these complaints were against an official that has worked or is working in any of the ministers' offices?

Mr Wann: We would absolutely prefer not to provide any information on any of the three, at the risk of compromising the investigations.

Senator RUSTON: Can we move on to food.

Prof. Murphy: In aged care, I hope!

Senator RUSTON: No—I'm just a little hungry! Obviously, one of the election commitments of this government was an improvement in food in aged care; I wondered what work had commenced in relation to the food commitment of the election.

Mr Maldon: There have been a range of measures that have been put in place in recent times. The first thing that's been happening is that we've been looking at strengthening accountability, so we've developed a dedicated food nutrition standard which will better reflect the expectations of older Australians in relation to the delivery of food and nutrition and their dining experience. In addition to that, we've strengthened reporting requirements.

We've mandated reporting against a number of elements through the quarterly financial report to make sure that aged-care providers report expenditure on a range of metrics, including dietician involvement, expenditure on fresh and processed food and also food preparation models—things like cook-freeze, cook-chill, cook fresh and those sorts of things. In addition to that, the funding uplift which has been provided through the basic daily fee supplement has been rolled in on an ongoing basis to all residential aged-care facilities and to MPS and NATSIFACP.

We've been improving transparency by continuing to look at what information we can publish in relation to service providers. Through the star rating system, which we hope to launch soon, we'll be looking at feeding in a number of elements which cover off food. To give you a few examples of that, there will be consumer experience, where we're asking residents, 'Do you like the food here?' There will also be a range of quality indicators where food has an impact—things like unplanned weight loss, falls and pressure injuries. In addition to that, service compliance ratings include an element of regulation. If food is picked up in that element, that will also feed through, and, in relation to care minutes that are reported through there, that can cover food service staff as well.

Ms Laffan: I'd just add one more thing. There is $5 million to the Maggie Beer Foundation to undertake sector education and training.

Senator RUSTON: Has that been provided to her foundation as yet?

Ms Laffan: Not as yet. It was provided in the recent budget. So we're currently working through the grant agreement process.

Senator RUSTON: So what has the Maggie Beer Foundation explicitly been asked to do for that $5 million?

Mr Lye: They're doing sector education, working with aged-care chefs and cooks on how to source, prepare and serve more nutritious and interesting food for aged-care residents.

Senator RUSTON: When are the new food standards due to be in place?

Ms Laffan: That's currently out for public consultation as we speak. Obviously we'll be looking at feedback that we receive through that consultation process, but I expect those new standards will be in place in alignment with the commencement of the new aged-care act.

Senator RUSTON: I'm just wondering: in the process of doing this, has the government engaged, or has the department engaged, with Dietitians Australia?

Mr Maldon: Absolutely. I can confirm that.

Senator RUSTON: What were the outcomes of that meeting? Have they been used to inform your decisions around the development of standards and the like?

Mr Maldon: Yes. They were really clear that there needs to be involvement of accredited practising dietitians, particularly in menu design. You'll see that that's been included as a specific requirement in the standards. We're also pleased to see that they were stating that they've had that outcome in the context of recent media. They're quite positive about the food and nutrition standard.

Senator RUSTON: In relation to those aged-care facilities that have not spent the $10 a day, or who've spent less than $6 a day on food, how many providers, to date or at the moment, are not meeting their obligations in relation to the $10 a day, or are as low as $6 a day?

Mr Maldon: I might just provide some clarification around that. The $10 provided to providers was provided to uplift care and services and could be used across a range of things, including staffing. But certainly the reporting requirements put a really clear focus on food. So, when we say that there are services spending less than $10 on food, there's not necessarily a requirement, as such, to be spending more than that. And we do need to be careful with that, because there are a range of different food delivery models in industry and, actually, we've seen quite good-quality food delivered for reasonably economical prices where there's a really significant scale of economy, if you like. What I would say is that we have to be careful about reviewing the expenditure. It's an input measure and it is relevant, but we need to look at it in the context of the food delivery preparation model and then the outcome measures—so, again, consumer experience, quality indicators and those sorts of things.

Senator RUSTON: You're telling me that a facility could reasonably be spending less than $10 a day on food per resident and that would be okay and they would meet standards?

Ms Laffan: I will just clarify that, having said what Mr Maldon has said, we have referred those services that are spending less than $10 per resident per day to the Aged Care Quality and Safety Commission to look at, amongst other evidence and information received.

Senator RUSTON: If my mum or dad is in an aged-care facility and that aged-care facility is spending $6 a day on their food, how do I know that?

Ms Laffan: That would be an input as part of the quarterly financial report that Ms Strapp was talking about earlier. That will be released in February next year.

Senator RUSTON: What possible reason could there be to not provide the names of facilities that are not providing at least $10 a day of food for their residents? Are you saying that that piece of information is not available?

Senator Gallagher: Is that something you'd agreed to—to publish a list of names?

Senator RUSTON: No, not at all.

Senator Gallagher: Okay. You just seem shocked about it, that's all.

Senator RUSTON: No. I'm just interested to understand, because one of the things that the Albanese opposition were very strong on in their budget replies—

Senator Gallagher: Yes, fixing up your mess in aged care.

Senator RUSTON: was to deal with the food in aged-care facilities. It was one of the five platforms.

Senator Gallagher: That's right. So we're repairing the mess.

Senator RUSTON: I'm just interested in the additional $10-a-day amount. I'm just interested to understand, from a transparency perspective: if I, say, were a family member of somebody in an aged-care facility, would I be able to get access to data to understand whether that facility was meeting its requirements of $10 a day?

Ms Strapp: I can answer that. One of the things that we're working on at the moment, which is consumer focused, is a report that will be made public that will include details, from each facility, of the amount spent on food. So it will be public information that consumers can look up and will include a range of information. It will include the amount that is being spent on food per day and also a comparison with other like facilities.

CHAIR: The committee's going to suspend now for 15 minutes. We will return to you at the end of the tea break.

Proceedings suspended from 21:00 to 21:15

CHAIR: We're continuing with questions in aged care.

Senator RUSTON: I'm following on from some of the previous questions around food. What action is taken against homes where the quality and safety commission or whoever assesses this deems the food spend or the food to have been inadequate?

Mr Lye: While Ms Anderson is coming up, I'd like to restate that anyone who's spending less than $10 is getting referred to the commission for it to follow up.

Senator RUSTON: Maybe I could go back to you, Ms Anderson, to ask how many facilities have been referred to you for this purpose.

Ms Anderson: We've had two tranches of information provided from the department—quarters 1 and 2 in the reporting and quarters 3 and 4. In fact, I reported to a previous estimates on what we did with quarters 1 and 2, but, to recap, there were 883 services referred to us with reported expenditure of less than $10 per resident per day, and that was in March. Then, for quarters 3 and 4, there were 691 services. So there was an overall improvement between the first two quarters and the second two quarters, and there was some overlap but not a lot. We looked at the two tranches of services, and we've taken action on the first tranche, which I can talk about. Of the services referred in quarters 1 and 2, 37 per cent had improved their expenditure such that they were not included in quarters 3 and 4. So one-third of the services were not in the second reporting period; about two-thirds of the initial set, however, did remain in that tranche of services referred to us.

Senator RUSTON: Given that in the first instance the 883 were identified and 37 per cent of them have undertaken action that would reflect the improvement that you would expect, whereas the other two-thirds haven't, what action would the commission take against those other two-thirds?

Ms Anderson: The point I'd start with is one that Mr Maldon has already made, which is that there's only a weak correlation that we have been able to discern between reported expenditure on food per resident per day and compliance with the quality standards. That is fundamental to understand. When we looked at the data which was referred to us in quarters 1 and 2, we identified 381 services which we on our risk profiling understood to be services at medium risk of noncompliance with the relevant quality standards. That's not just expenditure on food provision per day; we also took into account the complaints history, the past record of noncompliance and, as I think Mr Maldon also mentioned, the quality indicator on unplanned weight loss. So we took all that together, and

we understood that service with that constellation of factors. We identified 381 that were at medium risk of noncompliance, and there were 42 that we identified at higher risk of noncompliance.

Senator RUSTON: Okay. So can I just ask: would the 42 that you're talking about have been deemed not only not to have spent the money but also, by your assessment, not to meet an appropriate or adequate standard? Obviously there must be a standard in here somewhere that's the trigger for you to decide whether a facility is seriously not looking after the nutrition of its residents.

Ms Anderson: Just to clear, I'm talking about categories of risk of noncompliance, not evidence of noncompliance. There is an important difference.

Senator RUSTON: What about evidence of noncompliance?

Ms Anderson: We visited 48 services, including those 42 in the high-risk category. We found evidence of noncompliance in three of those services in relation to food related standards. That goes back to what I was saying earlier in terms of the weak correlation between reported expenditure and actual evidence of noncompliance. In fact, what we found in some of the other services was evidence of innovation and consumers who were very pleased about their food and dining experience in those services. So I think we just need to be careful. It is a crude measure which is useful but not the complete picture when it comes to assessing food, nutrition and the dining experience for aged-care consumers.

Senator RUSTON: I'm just at a bit of a loss to understand. Food has been such a big issue and it was a particularly big platform in the election.

Senator Gallagher: It's been a big issue for years—neglect.

Senator RUSTON: Rightly so, Senator Gallagher. So I'm just trying to understand. You've got 883 reported as not meeting the expenditure standard that's been built in there. Only 37 per cent of those have improved that expenditure standard between the first two quarters and the third and fourth quarters. You've got 381 of those facilities where you believe that the quality standards are at risk of not being met, and there are 42 where you think the standards are at high risk of not being met. I go back once again to this question: if I am a family member of someone at one of these facilities, at what point am I told that there is a significant risk that my parent or loved one is not getting a standard of nutrition or care that I think most Australians would expect in an aged-care facility?

Ms Anderson: Where we make a finding of noncompliance which leads to a regulatory action, that is a published report and that is information which is imparted to consumers by the provider, and we may also be involved, depending on the regulatory action we take. So that information is available. We would also increasingly look to providers to disclose this information. Indeed, the new legislation recently passed as amending acts places additional requirements on providers to disclose far more about the way in which they are using taxpayers' and consumers' funds.

Senator RUSTON: I'm not so much concerned about them disclosing that information to you; I'm concerned about the disclosure of the information to the—

Ms Anderson: No, this is public reporting required of providers. May I make one more point?

Senator RUSTON: Yes, sure.

Ms Anderson: From a regulator's perspective, what we're seeing is changes in behaviour by providers, and that's a good thing. When you look at quarter 1, quarter 2, quarter 3 and quarter 4, 35 per cent in quarter 1 were reporting expenditure below $10; 31 per cent were doing so in quarter 2; 28 per cent were doing so in quarter 3; and 22 per cent were doing so in quarter 4. That is music to a regulator's heart, because what we're seeing is that providers are adjusting their behaviour, making considered choices and resetting priorities to ensure that they are increasing their expenditure, because they are required to report it.

Senator RUSTON: Okay. What I'm just trying to understand is: at what point in time is Australia going to actually know? Are you going to report the names of those that have been deemed inadequate since the $10 supplement came into place? At what point is this encouragement, because they have to report to you, going to be sufficient for you to be satisfied that they're taking action? There are still a lot of providers that are clearly not meeting their $10 a day standard.

Ms Anderson: But who may be delivering a good consumer experience on food.

Senator RUSTON: So why are we bothering with this, if you don't think this is—

Ms Anderson: Because it's one important indicator of a suite which gives us a way to understand providers and the way they're managing this responsibility.

Senator RUSTON: I'd be keen to understand, when we see you back here in February, how we're going to provide this kind of information to consumers, because clearly this is a pretty useless piece of information from an FOI. It's just black pages.

Ms Anderson: I would be very pleased to talk about this again. We are taking it very, very seriously.

Senator RUSTON: Thank you very much. Finally, on food, what regulatory action would be taken against somebody if they were eventually deemed by you to have been non-compliant and are not responding?

Ms Anderson: If it were on food alone, then it might not reach the threshold for a noncompliance notice. It probably would require a direction from us to revise their plan for continuous improvement in relation to food and nutrition.

Senator RUSTON: And if they don't revise their plan?

Ms Anderson: They are required to. That's the direction we issue. And we monitor—

Senator RUSTON: Do they get a fine or anything?

Ms Anderson: Not specifically in relation to breaching a direction, but we can certainly consider regulatory action. Noncompliance with a direction from the commission is taken very seriously and can lead to a more intensive engagement by us with the provider and to enforcement action, if the level of risk requires that level of response.

Senator RUSTON: How many providers have you named so far in relation to noncompliance? You said you'd listed them on the website, which I'll go and have a look at in a minute. No-one?

Ms Anderson: We've not listed them under a heading of 'noncompliance with food and nutrition requirements'. If we prepare a performance report following a certain sort of assessment of performance, then it may be listed as non-compliant within that performance report for that service.

Senator RUSTON: Once again, if I'm the loved one of somebody in one of these services, at what point do I get that information?

Ms Anderson: That is available online to everyone.

Senator RUSTON: Once they've been deemed to be non-compliant. If they got a direction, would I know that they'd been given a direction?

Mr Lye: There will be that. Ms Strapp talked to you about the compulsory reporting that will flow through to consumers and their families. I think we can also take you through, if you'd like, the way the star ratings will work. For providers who aren't doing the right thing or aren't doing well, that will influence their star rating. So it'll be quite transparent for people to see that they're not delivering the quality against their peers, and that will be available to consumers, families and the general public.

Senator RUSTON: So the star rating actually goes through various elements of care?

Mr Lye: We can take you through that detail.

Senator RUSTON: I won't hold us up tonight, if Ms Strapp might provide that information.

Mr Lye: The star rating is Ms Laffan's.

Senator RUSTON: Sorry, Ms Laffan.

Ms Laffan: Certainly, one of the factors is compliance.

Senator RUSTON: I'm really keen to understand the transparency and how that's actually going to flow through to the individual families of people.

CHAIR: Senator Ruston, are you happy for me to pass the call to Senator Rice?

Senator RUSTON: Yes, of course.

Senator RICE: My questions are to Ms Anderson. I want to start off with some broad statistics about where we're at with complaints to the commission. How many complaints at the moment have you got that are currently live?

Ms Anderson: I don't think I'm going to be able to answer that. I've got lots of other data for you, but I'm not sure I have data on complaints on hand. I'm happy to take that on notice and come back to you—possibly within this session, because it's a piece of information that we look at very often. I just don't think it's in my notes.

Senator RICE: That's a pity. What's the ballpark, if it's information you look at regularly?

Ms Anderson: It's probably what we carry forward from one month to the next, I suppose. We have input and we have output, and then there's an amount that we carry forward. I am not going to—

Senator RICE: But at any one point in time—

Ms Anderson: I'd rather not guess. I will get the information for you, I promise.

Senator RICE: What's the average time between when a complaint is lodged and when it is resolved or dismissed?

Ms Anderson: We reported for 2020-21 that our KPI is resolving 80 per cent of complaints within 60 days, and we reported achievement against that KPI of 67 per cent of complaints within 60 days, which is clearly well short of our expectation. The reasons for that include that we have been paying particular attention to the longer-run complaints, which are typically the far more complex ones to resolve. When we close a long complaint, which has been with us for, say, 90 days or 100 days, it moves our average quite considerably. The way in which the KPI is measured actually, quite clearly, pushes down that average with every long complaint that we close. As we are getting to the end of those longer complaints, we fully expect, and have projected, an improvement in our KPI, so that 67 per cent should be turning around, though it has taken a hit. We're doing our level best, including increasing our staffing, to get on top of the rising volumes.

Senator RICE: There are rising volumes, but you seem to be indicating that you are reducing the number of long complaints that you currently have.

Ms Anderson: That's correct.

Senator RICE: Can you take that on notice, or is this information publicly available on your website on the length of time of complaints?

Ms Anderson: I don't believe we publish that specifically. I'm very comfortable with providing that to you.

Senator RICE: What's the longest outstanding complaint?

Ms Anderson: I don't know. Some of the complaints have over 15 separate issues in them, and some of those issues are immensely complex. We may resolve 13 of the 15, and then two issues enable or ensure that the complaint remains open until they also are resolved. We do have some complaints which are over 130 days old.

Senator RICE: I'm surprised you have ones that are considerably longer than that as well.

Ms Anderson: We probably do. I just don't have the chart in front of me.

Senator RICE: If you could take that on notice.

Ms Anderson: Yes.

Senator RICE: In terms of providers who have particular clusters of complaints, you obviously take a risk management approach. Do you pay more attention to those providers? How do you identify those? Walk me through your process. When do the alarm bells go off so that you realise you're going to have to be paying more attention to this provider? What then happens?

Ms Anderson: Each complaint is logged in our system and becomes available for every other person within the commission in terms of the work that they're doing. Every complaint that is received in relation to a particular service is logged against that service and becomes risk intelligence for a quality assessor, for example, who may be contemplating a visit or may have some visit scheduled—maybe a site audit for reaccreditation. That data is scooped up and becomes part of the information brief, which gives them a line on certain things they would look at, questions they would ask consumers and so on. In addition to that, we also have a scaled sequence of levels in terms of the assessed level of risk of a particular complaint. For complaints which are assessed as being very high risk in terms of a consumer having experienced harm or other consumers possibly being exposed to the same harm, that issue, that complaint, will be referred immediately to my quality-monitoring team, and typically they will stand up a site visit within the week. They will look at the detail, but, typically, if it's referred with that sense of urgency about the risk assessment, it will lead to a very rapid onsite visit. The quality assessors will assess the particular issue or do a broader-scale assessment against the standards and reach conclusions about compliance.

Senator RICE: Is information about complaints against particular facilities made public in any way?

Ms Anderson: No.

Senator RICE: Do you think it would be appropriate information for the public to know? It's the flipside of the star ratings, isn't it—the star ratings will tell you that you've got five stars or one star.

Ms Laffan: I think this is a difficult question. As Ms Anderson would agree, sometimes complaints are a sign of a very healthy aged-care provider, where residents feel that it's easy for them to make complaints and that those complaints are heard. Often complaints are a sign of a healthy service. There is a bit of a balance there as to what number of complaints makes a service a bad service. The number of complaints doesn't necessarily reflect the severity of complaints. This is something we'll look at in the context of the new aged-care act.

Senator RICE: I accept the number of complaints isn't necessarily a good representation, but the factor you identified, that you've got a cluster of complaints—I would've thought that would be information that should be shared.

Ms Anderson: First of all, we have progressively made more information available about complaints over time, and we continue to keep this under review. I understand exactly your level of interest in this. We've looked very closely at the ways we can do it, carefully and sensibly, so that we avoid the risk to which Ms Laffan was referring, but we nonetheless enable the transparency that is valued by everyone.

I would also make further reference to what has already been mentioned—that is, the obligations that now apply to providers to publish this material in the general domain, to make this information known. Complaints matters are squarely within the set of issues currently being contemplated for public reporting by individual providers. That, to my way of thinking, is exactly where the responsibility should be. They should be the ones to disclose because the governance responsibility and the leadership we are looking for from providers to take responsibility for that, and then to be—

Senator RICE: Why would they do that unless they were compelled to do that?

Ms Anderson: Then there will be compulsion, or a mandate, about publication of complaints. We can say certain things about them, but if they say certain things about themselves then they're being accountable to their consumers.

Senator RICE: That's going to be part of the reporting as part of the star ratings, is it?

Ms Anderson: Not star ratings. My understanding is it's part of the suite of areas being considered for requiring providers to report against.

Senator RICE: Can you take on notice the details as to what that process entails, in terms of it being considered; I don't want to go into the details now.

Ms Anderson: I think that would be for the department.

Senator RICE: You note on your website that you may not take action where the issue is part of a coronial inquiry. How does that play out in practice? Do you stop an investigation if somebody dies and there's a coronial inquiry, and do you restart it again afterwards?

Ms Anderson: We are very clear that we do not investigate the circumstances of an individual's death, because we don't have jurisdiction in that regard. We are more exercised by the quality and safety of the care which surrounded that event. If it is a serious incident, it's reported to us and we look at it through that lens as well. We can continue our work but it really depends on the circumstances. There have been occasions of which I'm aware where the work of the coroner has meant we have put our work on pause, but in other circumstances, depending on our lens—what we're looking at, the way in which we would proceed with our work—it may be that it's sufficiently divorced from the interest and the legal coverage of the coroner that we can continue. We are very attentive to not crossing lines, and we definitely don't want to be at risk of continuing.

Senator RICE: So it's a case-by-case basis?

Ms Anderson: Yes.

Senator RICE: I have a question which cuts across a question Senator Ruston asked, about where someone makes a commitment to you and then is noncompliant and breaks that commitment. I've heard direct accounts of a provider making a commitment as part of the complaints process and then refusing to honour it. What would be the consequences?

Ms Anderson: If we knew about it—and I expect we would, either because there would be a further complaint or because we would find out about it at a subsequent visit or in some other regulatory activity—then their failure to honour their agreement to us would be a matter for us to consider as the regulator, and it would be an argument for escalating our regulatory action. It may not be the only argument but it would definitely increase their risk profile for us and put them in a different category where we were less trusting of them as a provider. It would not go well for them.

Senator RICE: In terms of regulatory action, would there be actual penalties on them? What are the consequences?

Ms Anderson: I know what you're reaching for, but it's not a case of strict liability. As a risk-based regulator, we must be proportionate to the level of risk of harm.

Senator RICE: Have you imposed fines or other consequences for people who have breached undertakings to you?

Ms Anderson: No. The availability of fines is very circumscribed in the current act.

Senator RICE: So that's never happened. But you know of providers that have breached undertakings?

Ms Anderson: And we have doubled down in relation to those providers. They don't get away with it.

Senator RICE: What are the most significant consequences that have been meted out to providers?

Ms Anderson: I'm not going to do this anecdotally; I cannot summon to mind a particular case. I can say, with confidence, that our trust in them to do the right thing plummets, which means they move into a high-risk category, which means we will be more inclined to take stronger regulatory action, which might look like a noncompliance notice, a notice to agree or a sanction.

Senator RICE: I now want to move to a particular case that's been raised with me—and I have got permission to share it; I've got an email from them saying I can share it, and I think it has been foreshadowed with you. It's the case of Alvin Barker. Do you know the details of this person?

Ms Anderson: I know you have permission to share it but I do not. That leaves me in a difficult situation. I feel very uncomfortable talking about an individual case.

Senator Gallagher: I think that's fair enough, Senator Rice. Can you take this offline and talk about it, or raise the issues rather than—

Senator RICE: I'll raise the issues. This is somebody who entered an aged-care facility without a significant medical issue, but one developed in the two months they were there and they ended up in hospital. They almost had a leg amputation but didn't because their doctor decided they wouldn't survive the surgery, and they went into palliative care and died shortly thereafter. The case was raised with the commission and a complaint was made; I have a copy of the response.

Senator Gallagher: So the complaint's around access to medical care or health care within the aged-care facility.

Senator RICE: In the summary of the case there were statements saying they weren't treated well, and there were various training and remediatory actions the aged-care facility was required to undertake to make sure they were doing more training with wound care so that this wouldn't happen in the future. At the very end of it: 'For the reasons detailed above, I consider the provider has addressed several of the identified concerns. Given the ongoing action taken by the commission to ensure the service becomes compliant with the Aged Care Quality Standards, I've decided to end the resolution process on the basis that the relevant provider for the issue has addressed the issue to the satisfaction of the commissioner.' I have a copy of their performance report, and, basically, they're noncompliant. An overall assessment of this service was done, and they're largely noncompliant against all the standards. The partner of this person was devastated, and my heart goes out to them; it's an awful thing to lose your partner in these circumstances. They are unhappy because they don't see that there have been any consequences, other than the provider having been told, 'You've got to do more training and lift your game.' There hasn't been an apology, and there has been no acknowledgement in any way, or in any sense restitution for them, that this appalling treatment occurred at this service.

Senator Gallagher: Obviously, my sympathies go to the individual complainant and their family involved in this. I think, if they are after feedback or information, it's probably not going to be resolved in an estimates committee, but I'm sure it—

Senator RICE: But it's the general point that I want to raise through this example.

Senator Gallagher: Is it the general point or is it the individual? You're saying that they are not happy with the resolution, in which case there does need to be something else done on that front, because I think that is—

Senator RICE: Similarly, as I was saying, in terms of fines or regulatory action, you can have serious things happen—people end up dying—and yet all that happens is that the provider has to do more training and the complaint is considered to have been resolved.

Ms Anderson: I think we have let that consumer's family down in our failure to communicate adequately what we've done. We've done a lot more than that but we've not let them know. I think that's a problem for us that we need to look at closely, because that complainant doesn't fully know the action we took. We received the complaints, and the very next week we stood up an unannounced site visit. We found them noncompliant on eight requirements under standards 2, 3, 7 and 8. We also received a couple of serious incident notifications from the service, which were escalated within the commission to our investigations team, and we actually undertook an investigation, which provided further information about the noncompliance.

We issued the noncompliance notice at the end of August, and the service gave us an undertaking to remedy, which is still on foot. The undertaking to remedy doesn't close until 28 November. At that time or immediately

after—I'm saying this at an estimates hearing, which will get back to them, but anyway—they will undergo another visit. We will find out what they've done; we'll find out how successful the training has been; we'll find out whether they've done the training. Now that they've been forewarned, they'd better get the training done in the next three weeks. If they are at all recalcitrant, slow or less than fully enthusiastic about the remedy that they have undertaken to fulfil, then there will be consequences, there'll be further action. But we did not let the complainant know, and I regret that.

Senator RICE: Has there been an apology from the provider?

Ms Anderson: I couldn't say. I'm not aware of that.

Senator RICE: So, at this stage, there hasn't even been a requirement for an apology?

Ms Anderson: We don't have powers to require an apology. We talk to providers and say: 'This person is genuinely devastated by what has happened. Do you understand what went wrong? What are you going to do to put it right?' In that conversation, we would expect them to volunteer: 'Of course we will talk with the complainant. We will have that conversation.' You gave me two hours notice; I don't have that bit of information in front of me. We may know that some conversations occur, but I don't have that information with me.

Senator RICE: I acknowledge that you feel that you let them down, but to me it's deeply distressing that, almost 10 months later, when the letter from you came to them it didn't include that information, and they are still feeling bereft and absolutely let down. They don't feel that the quality commission is taking the action that should be taken in response to the death of their partner. I'll leave it there.

CHAIR: I just remind committee members that we were due to come to our friends in sport.

Senator RUSTON: Not till 10.

CHAIR: Well, it's 9.49. I'm just letting you know we're getting there.

Senator RUSTON: We haven't run over yet.

CHAIR: No, I'm just foreshadowing that that's where we're aiming to head. So, to the officials waiting patiently: we are coming.

Senator RUSTON: I'll just quickly go back to the exemption process in relation to 24/7. What happens if an aged-care provider either is not eligible or is deemed not to get the exemption? If they have been through a process of genuinely trying to hire the necessary registered nurses and have not been able to do so, what happens to them then?

Dr Hartland: The first consequence would be that they wouldn't be paid the supplement if they were otherwise eligible for the supplement, because they wouldn't have incurred the cost and therefore don't need the additional funding. They may also be referred to the safety and quality commission, and Ms Anderson would—

Senator RUSTON: That doesn't sound like a very scary thing to happen to them.

Dr Hartland: I think the answer Ms Anderson gave before was that it would feed into their regulatory assessment of the risks of that provider.

Senator RUSTON: When will these consequences be detailed in terms of actions for noncompliance?

Dr Hartland: I think they're available in our publicity material already. I'll just check whether that's the case.

Senator RUSTON: I couldn't find anything when I went looking for it.

Mr Richardson: I think those consequences, as Dr Hartland said, would be referred to the commission for them to undertake their existing processes.

Senator RUSTON: Okay. Is there anywhere in the process a best-endeavours defence in relation to being able to comply?

Dr Hartland: Well, if it got to regulatory action, the regulator would look at the totality of the providers' systems and processes and the way they meet the quality standards as a whole. So what they're doing in a whole range of other areas to ensure the quality of their care would come into consideration then.

Senator RUSTON: Would the same processes be in place for a noncompliance with 40 minutes of care when the AN-ACC model comes in in October, or are they a different set of—

Dr Hartland: They are slightly different.

Senator RUSTON: Are they publicly available?

Dr Hartland: We have material out on 40 minutes of care. They are different. They're treated differently. The first line about the 40 minutes of care is that it feeds into the STAR rating system—as indeed does the 24/7. Sorry, I missed that before. Providers, as we discussed on Tuesday, will report on their—

Senator RUSTON: I'm just asking about noncompliance.

Dr Hartland: Yes. I'm going through the ranges. Noncompliance starts at a whole range of levels. So the first level of compliance is around the publicity and ventilating their performance against those standards. We also will develop a function to check that their reporting is accurate. Consumers will be able to make complaints. In addition, if they don't meet their care, they may well be referred to the quality and safety commission.

Senator RUSTON: Is that why additional funding has been made available to the quality and safety commission, because they believe that there are likely to be more referred because of an inability to meet these requirements?

Mr Richardson: I'm not aware of the commission's funding in relation to these measures. Sorry.

Mr Lye: There's a capability review being conducted at the moment on the commission, headed by David Tune. The intention of that capability review is to look at the resources and capability and structure of the commission to do the job that we're asking them to do with all of these changes in aged care, so that'll certainly be part of it. They're currently looking at the resourcing model for the commission, so one of the questions for them will be: what resources and capability do they need to enforce these measures that we're introducing?

I should also say, just coming right back to the act, that we are actively looking at the regime of compliance and penalties as part of the new aged-care act. We'll be happy—possibly not in the last five minutes but next time we talk—to take you through what's contemplated there.

Senator RUSTON: Penalties for the 40 minutes are the AN-ACC penalties or penalties for the—

Mr Lye: Penalties under the act, generally, for noncompliance.

Senator RUSTON: Noncompliance. So that could include 24/7 as well as the care minimums?

Mr Lye: It could include everything under the act.

Senator RUSTON: When did you say they would be available?

Mr Lye: We could start the discussion. I'm presuming you don't want to talk through it tonight, but we are—

Senator RUSTON: I don't think the chair wants me to.

Mr Lye: obviously looking at the future of the industry.

Senator RUSTON: My very strongest advice has been that the concerns that are out there at the moment are that there is still a lack of detail about eligibility; exemption; discretionary exemption, which I believe sits with you, Professor Murphy, in terms of the discretion to accept or decline an exemption; the rules around how that exists; the rules around what will occur in the case of noncompliance; and whether there will be any best-endeavours defence associated with it. I know the sector is concerned about the bluntness of the tool that you're proposing to put in place for exemption. I certainly know that they would prefer it to be based on a circumstance as opposed to just a location or a size. There are a whole heap of things here that I think are causing great distress to the sector because they don't know the answer. The sooner you're able to get that information out to them—I think that would be really super.

Mr Lye: Like Dr Hartland has said in relation to those things, the information is out in the public domain. He was talking more generally—

Senator RUSTON: With the greatest amount of respect, Mr Lye, I haven't seen the answers tonight to the questions that I've been asking. You're saying that the penalties are going to be contained in the Aged Care Act. The Aged Care Act hasn't—

Mr Lye: No. I was making a more general point that your concern—what seems to be a concern from senators—about a lack of repercussions for people who don't do the right thing is one of the issues that we're looking at in terms of the new act. Dr Hartland and Mr Richardson have gone through, for both 24/7 nursing and care minutes, that some service providers are concerned about how you comply and how you don't comply. But the whole point of these measures is to address the lack of quality and the lack of safety in aged care that was identified by the royal commission—

Senator Gallagher: Neglect, under your watch.

Mr Lye: and we don't make any apologies for that.

Senator Gallagher: Let's not forget it.

Senator RUSTON: I absolutely accept that, Mr Lye. I also accept that we need to be careful in the process of getting to the outcome that I think everybody wants to get to, to your point that we don't end up causing

unintended consequences that actually cause significant distress to the people who rely on these services. Can I ask—

Senator Gallagher: That's not the aim of the additional investments. It's to improve the care—

Senator RUSTON: Can I ask one more question—

Senator Gallagher: Absolutely breathtaking!

Senator RUSTON: I asked on Tuesday night whether there was any modelling done in relation to the cost of the aged-care pay rise. Can I seek clarification of whether there is no modelling or the modelling is not available?

Senator Gallagher: It's not modelling. It's a costing. Is that what you're talking about?

Senator RUSTON: It's a costing. But what was the basis? You don't do a costing with nothing. You obviously have some information on which to do a costing. So has the department done any modelling around the likely costs of the pay rise increase?

Mr Lye: The department has just received the interim decision—it's not a final decision—from the Fair Work Commission, and we're—

Senator RUSTON: Yes, I understand that. I'm not asking for the modelling. I'm just asking: is there any?

Mr Lye: We're going through the process of looking at that interim result. We'll look at the different stages of the result and we will cost that for government.

Senator RUSTON: Can I be really clear here? You have not, up until receiving the interim decision, done any modelling to provide costings—

Senator Gallagher: What are you talking about with modelling? Can you explain—

Senator RUSTON: Sorry, costings—

Senator Gallagher: They are quite different things, modelling and costings.

Senator RUSTON: Would it be okay if I continued to speak to the official? I can speak to you all day, every day.

Senator Gallagher: No, you can't.

Senator RUSTON: I can.

Senator Gallagher: I have been very constrained, considering the subject matter tonight and the approach you're taking.

Senator RUSTON: Mr Lye, to be really clear, I'm wondering: had the department done any costings prior to the receipt of the interim decision? It appears to me that you're saying you hadn't. I want you to be clear. Did you provide advice to the minister as to the likely cost of a pay increase prior to receiving the interim decision?

Mr Lye: We've provided advice to government to enable them to—as the minister said on Tuesday night, the government has made provision in the contingency reserve for this. We have provided material as part of that government process, that cabinet process, but we have not costed what we received from the Fair Work Commission just last week. We're in the process of doing that.

Senator Gallagher: And we need further information from them, which I think was a directions hearing in late November. But, yes, the provision that we've made was costed.

Senator RUSTON: So we do have costings. I'll put the rest of my questions on notice, but there was a decision in July to change how deaths in aged care were reported. I was just wondering if you could tell us why it was changed.

Mr Lye: I'm not specifically aware of a change in definition on our part.

Senator RUSTON: Okay. I'll provide the rest of these questions on notice, but the way that we were reporting aged-care deaths appeared to change in July.

Mr Lye: I think we might have changed the frequency of reporting.

Senator RUSTON: You can't get the same level of detail that you were previously getting.

Senator Gallagher: Is it in relation to COVID deaths in aged care?

Senator RUSTON: Yes, COVID deaths—sorry, Minister. If you could provide me the advice as to the change—

Senator Gallagher: I think it's the timing.

Senator RUSTON: the timing and the like, the basis for the decision to make the changes, and who made the decision to change it—that would be really useful. But, given it's 10 o'clock—

Prof. Kelly: It was a decision of National Cabinet to move to weekly reporting, if that's what you're referring to.

Senator RUSTON: Okay.

Prof. Kelly: But we can provide details of course.

CHAIR: I think Ms Anderson is seeking to return some information.

Ms Anderson: Senator Rice, I did promise to come back to you in the session. You asked about complaints on hand, and it's 1,835.

Senator RICE: Thank you.

CHAIR: Can I confirm with colleagues at the table that everyone's comfortable to move on from aged care? Yes? Then we can release the officials. Thank you, officials.

[22:02]

CHAIR: We are moving on now to outcome 4, Sport and recreation, so if you relate to outcome 4 this is not your moment to leave. Is anyone seeking to make an opening statement? No? Excellent. I will give the call to Senator Ruston.

Senator RUSTON: Good evening, gentlemen, and thank you so much. What a rotten short straw to draw, to get the 10 o'clock stint on a Thursday night! Has the department done any modelling on the approximate cost to the Commonwealth of hosting the 2032 Olympic Games?

Mr Wann: I'm the chief operating officer.

Senator RUSTON: Still here!

Mr Wann: Yes, still here! I kind of look after sport as well. We've got Andrew here; he's the head of the Office for Sport, and Andrew can jump in at any time because he's the expert. In terms of the costings generally, they were all part of the host questionnaire that was part of the bid going forward. In that, Queensland went and gathered all the costs associated with the games—both revenue and the expenses. Part of that recognised—in terms of the philosophy of the games, which was to try and minimise costs—that they provide venue costs and the costs for the running of the games. The Commonwealth's part in all of that is that, at this stage, there is no commitment per se. No decision has been made. The nature of the support that the government provided at the time was in terms of the set of guarantees for things such as visas, taxation, security, telecommunications and things of that nature. That wasn't quantified. It was just a guarantee that it would be provided.

Senator RUSTON: So the Commonwealth has taken responsibility for security, immigration, visas, telecommunications et cetera?

Mr Wann: Yes. Separate to that, there was a commitment of the previous government to go fifty-fifty in certain other costs, dependent on fifty-fifty in terms of governance. It was only for certain costs. It was in relation to venue, or non-transport and transport. So that was not costed per se.

Senator RUSTON: So what you're saying is that it was largely in terms of infrastructure, and it was an agreement that there be a fifty-fifty split in the cost of the infrastructure that was required, as long as there was a fifty-fifty split in terms of responsibility and authority over how that would be expended.

Mr Wann: That's right. It was recorded as a contingent liability, though, because the costs weren't quantifiable.

Senator Gallagher: Not provided for.

Mr Wann: It was not provided for because it's a contingent liability. That's correct. So that's where we're at. The current government is in negotiations with the Queensland government on contribution and governance.

Senator RUSTON: Sure. Obviously the centrepiece of discussion in recent times has been around the upgrade for whatever activities are going to occur at the Gabba stadium. What is the department's understanding about the proposal in relation to the Gabba at this stage?

Mr Wann: That's not a matter for us in the department or for the Office for Sport.

Senator RUSTON: Who is it a matter for, in the Commonwealth?

Mr Wann: The infrastructure department is responsible for infrastructure arrangements. In this instance, the initial correspondence around negotiations generally is between the Prime Minister and the Premier. So that will come out of Prime Minister and Cabinet, in terms of questions.

Senator RUSTON: Okay. Would that also relate to the establishment or otherwise of an infrastructure oversight body that would sit within infrastructure or the department of the Prime Minister?

Mr Wann: They'd all be subject to negotiations.

Senator RUSTON: In terms of the department of sport, what are its obligations or commitments in relation to the Olympic Games?

Mr Wann: Our role would be in coordinating guarantees. The implementation of those guarantees would sit with other portfolios. Secondary elements may be in relation to legacy arrangements. But none of that has progressed in any significant way. The Queensland government itself is working through its position on legacy.

Senator RUSTON: Okay. On that basis, I will put the rest of my questions in relation to this on notice and send them through to the department of infrastructure and the Department of the Prime Minister and Cabinet, because clearly you're not going to be able to tell me about the relationship between the Commonwealth and the Queensland government in relation to the honouring of the commitment of the fifty-fifty infrastructure funding—unless the minister has something to add.

Senator Gallagher: I think your questions have been answered. The negotiations are ongoing.

Senator RUSTON: I've just asked people. Just take a step back. At the time, there was quite a lot of media around the agreement between the previous government and the Queensland government around the fifty-fifty funding deal around infrastructure, but I noticed earlier in the week that the Prime Minister was saying that he hadn't committed to that. I was just wondering—

Senator Gallagher: That was your commitment.

Senator RUSTON: Absolutely.

Senator Gallagher: Which you made and then didn't make provision for—so that's nice!

Senator RUSTON: I'm not moving away from the fact of that commitment in 10 years time. I just noticed that your Prime Minister has moved away—

Senator Gallagher: It was a commitment to share 50 per cent of the costs of the Olympic Games made obviously without any knowledge of what that would cost. That's how that agreement must have been reached. There was no knowledge of the costs.

Senator RUSTON: There were numbers at the time.

Senator Gallagher: Were there? They didn't feature their way into any budget paper, that's for sure.

Senator RUSTON: Well, no, because they're in 2032 and the like. I'm interested to know whether the Commonwealth is committed to—

Senator Gallagher: We are in close discussions with the Queensland government on all aspects of the Commonwealth Games: funding, infrastructure, legacy and governance arrangements.

Senator RUSTON: Commonwealth Games?

Senator Gallagher: Sorry, the Olympic Games and Paralympic Games.

Senator RUSTON: To that point, and it may be to you, Minister: what is the status of the negotiations in relation to any Commonwealth support to Victoria for the Commonwealth Games?

Senator Gallagher: Do we have any advice on that?

Mr Wann: We do. I'll hand over to Andrew.

Mr Godkin: There has been preliminary correspondence from Victoria, but we don't have much detail at all in relation to the full expectations of the Commonwealth there. There was, earlier on, an in principle undertaking at the time of the bid to support with the operational guarantees, the same that we did for the 2032 Olympics and Paralympics. We don't have any data on that yet. With the caretaker taking hold now in Victoria, I think we'll have to wait until after that process for any meaningful data to come up in relation to what the Commonwealth may or may not be asked to support in relation to 2026.

Senator RUSTON: Mr Godkin, in your experience in terms of these major international events, what kind of time frame would you think would be a normal time frame to be seeking this? Clearly the Commonwealth Games aren't that far away. Is the time that's left to be able to effectively deliver on these games in 2026 sufficient?

Mr Godkin: It varies a lot. We have a lot of major events coming up over the next 10 years, and we've hosted many in the past. The time frames vary a lot. Typically in the Olympic and Paralympic cycles it has tended to be about seven years. In this particular process, with Brisbane 2032, we have the benefit of a longer time span, but with other events sometimes they come at very short notice. We're dealing with some at the moment that have

been relocated from troubled parts of the world, where we had very little forewarning. I'm aware of others that are in the wings. It does vary a lot. In terms of 2026, it is a reasonably short time frame, but we're well practised in hosting these events, so I'm very confident that it will be very successful.

Senator RUSTON: Finally on the two lots of games, are the people at the table aware of the 10+10 strategy around sporting development? I'm assuming you would be interested in that, Mr Perkins. What progress has been made around gaining more general sporting leverage from these two amazing events that Australia has been able to secure? Are you satisfied that the necessary funding and provisions are being put in place right across Australia to make sure that Australian grassroots sporting organisations and kids playing sport are going to get the best benefit from these two great events?

Senator Gallagher: This is one of the priorities of Minister Wells. Every time I've heard her speak about these events, there has been a discussion about the legacy outcomes and investment into those areas. I can guarantee that the minister is very focused on these.

Senator RUSTON: Are the department and the Sports Commission engaged in this process?

Mr Wann: I'll start and then hand over to either Andrew or Mr Perkins. From the department's perspective, for sure we are working on a legacy framework that seeks to put in arrangements where these events would really generate outcomes across the whole range of government priorities. We're very deliberate about how you might do that. Part of that is ensuring that you get the appropriate information from event organisers and to be able to make assessments as to whether legacy activities will generate the legacy outcomes you're seeking. That work is ongoing at present. In terms of the events that we're talking about, obviously with the Commonwealth games we've got very little information around that. To see where the Commonwealth government's role may be still has to play out. To be honest, it's the same with the 2032 games, but we've got a lot longer runway before then.

Senator RUSTON: Do you have a view on the 10+10?

Mr Wann: More broadly, absolutely it's vital that, when we look at these big games, we try to make the most of the events and opportunities leading up to them and that, following it, that legacy plays out in a very real way.

CHAIR: Senator Ruston, Senator Pocock is seeking the call.

Senator RUSTON: Of course.

Senator DAVID POCOCK: Thanks, Senator Ruston. Thanks for your time. Mr Perkins, I'm keen to bring it back to the ACT for a few minutes, if that's alright, and get an update on AIS Arena: what work is being done, whether there is a plan, what all the upgrades will entail and if there's a timeline yet for that.

Mr Perkins: In this last budget round, funding was confirmed for the upgrade of the arena. There's a total contribution across all measures of $15.1 million. That will predominantly centre around improved fire safety, replacement and upgrade of all electrical and lighting systems, HVAC upgrades and seating. At this point in time, tenders are being prepared to go out for procurement. At this point, considering that we're already aware that there's roughly a 40-week manufacturing lead time on lighting systems for a venue like this, we wouldn't expect to be able to complete those works before the end of next calendar year. We're certainly pushing very hard, now that we're underway, to have that work done as soon as we can.

Senator DAVID POCOCK: On the wider AIS plans going forward: from what I've read, I understand your preference is not to sell unused land around the precinct—is that correct?

Mr Perkins: Certainly that question comes with a whole bunch of interesting complexities around the site itself. While I know that there has been conversation in recent history about the potential value that that could procure, the reality is that, while completed development of improved land could provide some funding of significant value, the actual land itself would not provide any sustainable outcomes or benefits. We also have a strong view that one thing that you can't build more of is land. At the moment, our facility is using roughly half of the scoped environment that is part of the Australian Sports Commission AIS campus. We have quite a significant amount of work to do to modernise the site to bring it up to current standards, to extend the industry capability and support that we would like to be able to provide, as well as currently working on how we would significantly improve the sustainability of the site as it stands at the moment. We are a very significant user of power and gas, which we would like to be able to wean ourselves off. The utilisation of the land to do that is something that we would expect would require the vast majority of the developable space that we currently have to be able to implement these plans fully.

Senator DAVID POCOCK: Do you have any idea of where you would want to put the solar on the site?

Mr Perkins: You are testing my geographic knowledge of the ACT at this point in time. I'm going to say on the backside of the site, towards Gungahlin Drive. Where the land starts to slope dramatically, it does have a favourable, sky-directional—

Senator DAVID POCOCK: It faces north, yes.

Unidentified speaker: Aspect.

Mr Perkins: aspect—thank you, Senator. That would be, at the moment, the type of proposed land that we would use for solar and battery farms. But we don't have a definitive plan on that at this stage. We do have some work being done to fully understand what our requirements would be and the best placement of those.

Senator DAVID POCOCK: Would that potentially be a trade-off with future development—if you committed that land to solar—or would it just be using unusable land?

Mr Perkins: Our preference is to go for the unusable space. As you would appreciate, when you start to look at expanding sporting facilities, one of the largest users of land metreage is playing fields. At the moment, we have one FIFA five-star soccer pitch as well as two other lower-grade grass pitches, including availability for AFL and archery, and two synthetic pitches. We already know that's not going to provide us with all the requirements that we need. The cost of doing any significant earthworks, or impeding on or pushing towards the freeway, would just not be viable or reasonable for us. We would utilise the flattest, most easily developable land for that activity. On the other side of the site, towards Braybrooke Street, where at the moment there is significant undeveloped car parking space, is where physical development of a plan—and these are proposals at this point in time, you would appreciate—around things like an innovation hub would encroach on those spaces.

Senator DAVID POCOCK: Is there an ideal or realistic time line for a precinct redevelopment?

Mr Perkins: Yesterday. The reality, as I'm sure many would appreciate, is that, while 10 years for Olympic and Paralympic games hosting seems like a long way away, the reality is that eight- to12-year-old abled and para-athletes who are aspiring to represent their country are today in need of support to be able to deliver, to be ready to compete and do Australia proud in 2032.

Senator DAVID POCOCK: I don't want to put you on the spot, but I've heard you say that a number of sports have contacted the AIS wanting to relocate. Are you able to share them?

Mr Perkins: At this point in time, they're exploratory conversations, mostly about development pathways. I think a lot of sports, in their assessments of historical success, have been trying to unravel some of the previous sustainability of development of future talent that they've had. That's been one of the things that has come up consistently for a couple of sports.

The reality, though, is that our site and the work that we're doing is very much focused towards providing continued support for national camp based programs. We are the most accessible sporting site in the country, with facilities that enable all of the high-performance athletes that we fund to be able to not only reside and eat but go through all of the training, recovery, sports science and medicine, technology, engineering and other requirements that they need, which is a significant part of the uniqueness of our site.

This year we are going to have in the vicinity of 175 camps, and these are all for high-performance athletes. We don't do anything other than high performance at the moment, due to our lingering COVID protocols. This year we should see just under 4,400 high-performance athletes attend the site at different times for training and development programs. From a utilisation and capacity point of view, we are already struggling. Any conversations that we would have about wanting to work with sports on a more permanent basis would need to also come with an assessment of facility and funding requirements, which we have not explored at all.

Senator DAVID POCOCK: Finally, do you have a preference for developing or selling Canberra stadium, Bruce stadium, to the ACT government? Where are discussions up to on that?

Mr Perkins: It's a matter for the ACT government and the federal government to have conversations around. Ultimately, the ownership and the long-term tenure of the facility, and any funding that would be required to potentially upgrade or develop that space, would need to be negotiated and funded through those two parties. But we are involved in ensuring that there is good collaborative and strategic assessment of all of the facilities on the site and what their future value would be.

Senator DAVID POCOCK: I have one question for Sport Integrity Australia. Firstly, thanks for what you do—I was drug tested far too many times over the years! I appreciate your professionalism and the work you do. I'm keen to get a quick update on the Australian Sports Wagering Scheme and where things are up to with that.

Mr Sharpe: Thanks for your comment. I'm glad that we were effective in our testing, because we never saw you on the other side of the market. We have now progressed the Australian Sports Wagering Scheme to the point

of identifying an operating model where the majority of the partners, through our extensive engagement, have provided input into that. That is now subject to a government policy decision when I take that back to government.

Senator DAVID POCOCK: So there will be a financial ask to make that happen?

Mr Sharpe: Yes, there will be. The matter was deferred until the next budget, so we'll be having a discussion with the minister in due course around the next steps for the Sports Wagering Scheme.

Senator DAVID POCOCK: Is match fixing an issue? Are you coming across a lot of instances or allegations of it?

Mr Sharpe: It's certainly of grave concern to me, particularly noting the gambling issues that have been identified with athletes. When there's gambling and when there are debts, you're vulnerable. When there's organised crime infiltration in sport and associations which are quite deep in professional sports in particular, as you would be well aware of, it certainly creates an environment that is vulnerable to match fixing. There is intelligence to suggest that. In our partnership with the Australian Criminal Intelligence Commission, which was seconded into Sport Integrity Australia, and with state law enforcement, federal law enforcement and, in fact, the wagering service providers, we have a lot of data to be able to identify trends and risks. Certainly, the greater the gambling issues in sport, the greater my concern.

Senator DAVID POCOCK: Are you satisfied that the current laws allow you enough access to gambling companies' data, or is that something that needs to be looked at?

Mr Sharpe: While the regulated gambling market in Australia is, I would say, disjointed at the moment, part of the Sports Wagering Scheme's role is to bring that together and look at how the sports wagering providers and the professional sports utilise their income towards developing education and integrity programs. Certainly, it will be enhanced by the Sports Wagering Scheme and bringing those partners together. There are significant relationships across law enforcement and wagering service providers where they willingly provide data for intelligence purposes. The real concern is the unregulated market. If you look at the unregulated betting market across the globe, in 2021 it was estimated to be about 1.7 trillion euros.

Senator DAVID POCOCK: Do you have a figure for Australia?

Mr Sharpe: I don't have a specific figure for Australia but it's quite significant. The unregulated betting market means—the South-East Asia betting markets are of concern because they're in our backyard. The more sports that are streamed, the more there is a market. Particularly as we target the professional sports—and we target the professional sports hard with all the partnerships—the displacement effect moves down the chain to other sports that don't have capability. That's why we've invented integrity offices with sports to build frameworks around match fixing, education programs and the like.

Senator DAVID POCOCK: Finally, have you had any indication from the new government as to whether you will receive funding in the next budget?

Mr Sharpe: I've had some discussions around my concerns about integrity threats. Already, with my initial approach—you may have seen this recently—the minister has announced a safety and sport division and an enhancing of our capability. It's been a very positive and very clear message to me that the government supports a stronger approach to integrity and all the data I'm putting forward. I think we will see sports wagering become part of the integrity framework.

Senator DAVID POCOCK: I saw the finance minister nod, so I think you're safe!

Senator Gallagher: I'm getting it from every committee. I've picked up a lot this week, of people going, 'This will be coming forward to the next budget.' I slump!

Senator DAVID POCOCK: Thank you.

Senator RUSTON: Did the department provide a brief to the minister in relation to Netball Australia's financial position in recent times?

Mr Godkin: I'm trying to recall whether there was a specific brief. I might have to check the records there. There were certainly some interactions with the office and with some of our partner agencies.

Senator RUSTON: Has the Victorian government reached out in any way seeking support for this funding commitment from them?

Mr Godkin: Not to the department.

Senator Gallagher: Not to my knowledge.

Senator RUSTON: You might take it on notice, Senator Gallagher, as to whether there was any call to the sports minister in relation to that. I assume there was no call to the ASC?

Mr Perkins: I'm not aware that there's been any contact.

Senator RUSTON: Is the federal government aware of whether the Victorian government has put any requirement on the Diamonds around their attendance in Victoria at particular national sporting events as a result of this sponsorship—for instance, that there will be more games played in Victoria than there would otherwise have been because of this sponsorship, because of Victoria's claim on them because of this $15 million?

Senator Gallagher: I think that's a matter more appropriately raised with the Victorian government. It's an agreement between the Victorian government and the Diamonds.

Senator RUSTON: I just asked if they were aware.

Mr Godkin: There's been no interaction with us on that. I saw some media reporting at the time that there may be certain requirements that come with that sponsorship, but we were not involved in any way in any of that.

Senator RUSTON: Do you think the commission should seek to find out details of this, given it is a national team, just to make sure the integrity of that national team is not compromised in any way because it has a state based sponsorship?

Senator Gallagher: Would you have had the same concerns about Hancock Prospecting as well? When you have a sponsorship arrangement between two parties, it usually comes with a bit of, 'For this money, we would like you to do this.' Or is it just the Victorian government you're worried about?

Senator RUSTON: I think it's just the unusual—

Senator Gallagher: There are a whole range of sponsorship arrangements in sport.

Senator RUSTON: I'm just asking a question. I'm not saying I'm concerned about it; I'm just asking if the department are aware of it and if they would be concerned if that was the case.

Senator Gallagher: You were asking if we were concerned about the national interest.

Senator RUSTON: It's a pretty straightforward question; I don't know why you're so defensive.

Senator Gallagher: I'm not defensive; I'm just wondering why you have an obsession with the Victorian government.

Senator RUSTON: I don't have an obsession with the Victorian government.

Senator Gallagher: You seem to. It's come up a lot in the last few days.

Senator RUSTON: Hopefully we will lose all obsession with the Victorian government very shortly!

In relation to the national curriculum in sport, I'm wondering what the department's role is in encouraging a strong inclusion of physical activity in the national curriculum and whether you've got any concerns about the level of sport being offered up as part of the national curriculum.

Mr Godkin: The key initiative there relates to the Sporting Schools initiative, if we're talking about the school sector, which is administered by the Sports Commission. Beyond that, I don't think there's any particular comment we can make.

Mr Perkins: At this point in time, a funded program in respect of Sporting Schools is our main engagement. That program has been very ongoing and quite successful in the overall delivery it's provided; since 2015 more than 13 million Australian children have participated in that program, with about 10,000 participating every day. More than 9,000 schools across the country are currently registered with the Sporting Schools program, and we expect 550,000 students per term are involved. Very pleasingly, 52 per cent of the funded schools for the Sporting Schools program are in regional areas—so the breadth of the program's delivery is quite significant and successful. I note, though, it is a program offered after school hours, not in the curricula.

Senator RUSTON: Has the Department of Education sought advice from any of you in relation to the level of physical activity and sporting activity that would be an appropriate level within the national curriculum?

Mr Wann: I'm not aware of anything in terms of the Office for Sport. I'm wondering in the context of preventive health more broadly—

Prof. Murphy: We can take that on notice.

Senator RUSTON: I might put in on notice with the Department of Education as well. One of the things we've often heard, travelling around, is there is a diminishing level of physical activity built into the national curriculum, particularly in high schools, which I imagine would be of great concern to you, Professor Murphy, in that we know young people continue to have physical activity as part of their daily lives. It is a very important

preventive health measure. If you're not involved in the national curriculum as it relates to physical education, perhaps you should be.

Prof. Murphy: We will take on notice whether we've had any interaction with them.

Senator RUSTON: Thank you.

CHAIR: Thank you very much for your attendance at our hearing today. We very much appreciate you being here late into the evening. This concludes today's hearing. On behalf of the committee I thank the ministers as well as officers from the Department of Health and Aged Care and agencies who have given evidence to the committee today. I also thank the secretariat and staff, and our friends in Broadcasting too, for their assistance. I remind senators the committee has agreed that any written questions on notice should be lodged with the secretariat by Friday 18 November 2022.

Committee adjourned at 22:38